HOLT EYE CLINIC

211 McAuley Court, Hot Springs, AR 71913 * 205 McAuley Court, Hot Springs, AR 71913

Offce: 501-624-0609 Fax: 501-624-6191 * Office: 501-624-6330 Fax: 501-624-1060

www.holteye.com

Children's Registration Form

This clinic accepts assignment on Medicare and Medicaid patients. All patients are expected to pay for non-covered services, their portion and the applicable copay on the date of service unless prior arrangements have been made. Thank you for your cooperation.

PATIENT: _____ **Date of Birth:** ____/____/_____ **Age:**_____
First Mid Initial Last

Address: _____
Street or P.O. Box City State Zip Code

Phone:(_____)_____ **Social Security #:**_____ ☐ **Male** ☐ **Female**

email:_____

Parent and or Legal Guardian Information:

Mother:_____ **Date of Birth:** ____/____/_____ **Age:**_____

Address:_____ **Phone:(_____)**_____
Street or P.O. Box City State Zip Code

Social Security #:_____ **Employer:**_____

Employer Address:_____ **Work Telephone:(____)**_____ **Ext:**_____

Father:_____ **Date of Birth:** ____/____/_____ **Age:**_____

Address:_____ **Phone:(_____)**_____
Street or P.O. Box City State Zip Code

Social Security #:_____ **Employer:**_____

Employer Address:_____ **Work Telephone:(____)**_____ **Ext:**_____

Please provide us with the name and telephone number of a friend or relative at a different address that we can contact in the event we are unable to reach you.

Name:_____ **Telephone:(____)**_____ **Ext.**_____

Referral Information:

Referred by:_____ **(_____)**_____
Doctor's Name Telephone

By signing this form, I hereby authorize:

☐ The release of any information concerning my exam or treatment for insurance purposes only.

☐ Payment directly to the physician.

☐ I have received / or was offered a copy of the clinic's Notice of Privacy Practices that became effective April 14, 2003 and was revised on S eptember 23, 2013.

NOTE: Please read the three statements above then check off the ones you are in agreement with. Please sign and date below, if applicable. You can refuse to sign this acknowledgement.

X_____ **Today's date:**_____
Parent and or Legal Guardian Signature Here

Insurance Information:

Please provide us with current primary and secondary insurance card(s) so that we can make copies, and bill correct insurance. If we have not heard from your coinsurance within two months after filing, you are responsible for any remaining balance.