1675 State Route 51
Jefferson Hills, PA 15025
Tel: 412 382 7155
Fax: 412 382 7133

MINOR

PATIENT REGISTRATION

Pittsburgh EYE Institute

Last Name _____ First Name_____ MI_____ Gender ☐ M ☐ F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Social Security # _____ Birthdate _____ Age ____ Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Home ___ Own ____ Rent

Father _____ Employer _____ Work Phone _____ SS#: _____

Mother _____ Employer _____ Work Phone _____ SS#: _____

Drug Store Name _____ Drug Store Phone _____

Primary Care Physician _____ Phone _____

Optometrist (if applicable) _____ Phone _____

How Did You Hear About Our Practice? _____

Who Referred You? ☐ PCP ☐ Optometrist ☐ Other Explain: _____

Name of Local Emergency Contact **(Someone not living with you)** _____

Relationship _____ Home Phone _____ Work Phone _____

Primary Insurance _____ Policy # _____ Group # _____ Eligibility Date _____

Secondary Insurance _____ Policy # _____ Group # _____ Eligibility Date _____

Vision Insurance _____ Policy # _____ Group # _____Eligibility Date _____

When ordering frames/lenses a 50% down payment will be required to process your order.

PLEASE HAVE YOUR INSURANCE CARDS READY SO WE CAN MAKE A COPY FOR YOUR CHART. THANK YOU

Authorization for Care: I hereby give my permission & written consent to **Pittsburgh Eye Institute LLC**, its physicians, optometrists, and employees to render any and all medical/surgical treatment as deemed necessary because of injury/illness.
Lifetime Insurance Authorization: I hereby authorize **Pittsburgh Eye Institute LLC** to release any of my protected healthcare information necessary to process my healthcare claims to all applicable insurances such as Medicare, Medigap and any other health insurance carrier I may have as well as major medical. I authorize and assign all insurance benefits to be payable to **Pittsburgh Eye Institute LLC** on my behalf for any services provided by the physicians, optometrists, or suppliers of this practice. I understand and agree that regardless of any insurance status, I am responsible for any balance on my accounts.

Workers' Compensation/Auto Accident: If your visit is a result of a workers' compensation claim/auto accident, please ask the receptionist to give you a separate information form so we can help you process your claims.

ADVANCE DIRECTIVE: DO YOU HAVE AN ADVANCE DIRECTIVE? _____ YES _____ NO
ASK OUR RECEPTIONIST FOR LITERATURE REGARDING ADVANCE DIRECTIVES.

PATIENT'S SIGNATURE (required)_____ DATE _____
Parent if patient is a minor I agree to the above

SPOUSE'S SIGNATURE (required)_____ DATE _____
Trustee/Guardian I agree to the above

If patient cannot sign, please state reason: _____

ALL CHARGES, COPAYMENTS AND/OR DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.

IF YOU ARE EXPERIENCING HARDSHIP WHICH WOULD MAKE PAYMENT IN FULL IMPOSSIBLE, PLEASE FEEL FREE TO SET UP A PAYMENT PLAN WITH OFFICE MANAGER.