

PATIENT REGISTRATION FOR MINOR
Tomoka Eye Associates

OFFICE USE ONLY

Dr. _____
Appt. _____

Referred By: _____
(If your insurance requires a referral, please bring it with you)

Patient Name: _____ Nickname: _____
 First Middle Last

Date of Birth: ____/____/____ Social Security # ____-____-____ Sex (circle) **M** **F**

Mother's Name: _____ Father's Name: _____
 First MI Last First MI Last

Local Mailing Address _____ Email address: _____

City _____ State _____ Zip Code _____

Other Address _____

City _____ State _____ Zip Code _____

Home Phone# _____ Cell Phone# _____ Alternate Phone# _____

A minor is defined as any patient who is under the age of 18. The person bringing the minor to their appointment is responsible for the account, regardless of custody and/or insurance policy holder information. Responsible adult is:

Name: _____ Relationship: _____
 First Middle Last

Date of Birth: ____/____/____ Social Security # ____-____-____ Phone # _____

Address (if different from above): _____

Please read and initial the following policies:

TOMOKA EYE ASSOCIATES HIPAA POLICY: Effective 4/14/2003

I have received and understand the HIPAA Privacy Policy for Tomoka Eye Associates/Tomoka Optical. Initials _____

TOMOKA EYE ASSOCIATES REFRACTION POLICY:

In Ophthalmology, the **refraction** is a clinical test used to determine the eye's refractive error and the best corrective lenses to be prescribed. This is a necessary part of the medical exam to provide the sharpest, clearest vision. In most cases, the **refraction** is required for continuation of care. The fee for the refraction is \$30.00 and may not be covered by your insurance company (including Medicare). I understand the refraction charges. Initials _____

I verify the information provided is true and accurate. I understand it is my responsibility to notify Tomoka Eye Associates of any changes to the information provided. I grant Tomoka Eye Associates providers and other technical staff permission to provide medical services including but not limited to evaluation, treatment and testing to the minor child.

Parent/Guardian Signature: _____ Date: _____

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