



**PEDIATRIC OPHTHALMOLOGY CONSULTANTS
OF SOUTH FLORIDA, P.A.**

BRUCE A. MILLER, M.D.
M. EDWARD GUTHRIE, M.D.
NEIL E. KANTERMAN, M.D.

PLEASE PRINT

PATIENT'S NAME: _____ MALE: _____
FEMALE: _____
first middle last nickname

SS#: _____ - _____ - _____

AGE: ____ BIRTH DATE: ____/____/____ HOME PHONE NO: (____) _____ - _____

ADDRESS: _____ APARTMENT NUMBER: _____

CITY: _____ STATE: _____ ZIP CODE: _____

MOTHER'S NAME: _____ SS#: _____ - _____ - _____

AGE: ____ BIRTH DATE: ____/____/____ BUSINESS PHONE NO: (____) _____ - _____

EMPLOYED BY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

FATHER'S NAME: _____ SS#: _____ - _____ - _____

AGE: ____ BIRTH DATE: ____/____/____ BUSINESS PHONE NO: (____) _____ - _____

EMPLOYED BY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

NEAREST RELATIVE OTHER THAN PARENTS: _____

ADDRESS: _____ PHONE NO: (____) _____ - _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____

POLICY HOLDER: _____ SS#: _____ - _____ - _____

GROUP NUMBER: _____ CONTROL/POLICY #: _____

INSURANCE ADDRESS: _____

INSURANCE PHONE NO: (____) _____ - _____

SECONDARY INSURANCE NAME: _____

POLICY HOLDER: _____ SS#: _____ - _____ - _____

GROUP NUMBER: _____ CONTROL/POLICY #: _____

INSURANCE ADDRESS: _____

INSURANCE PHONE NO: (____) _____ - _____

IMPORTANT: PRESENT INSURANCE CARDS WITH THIS COMPLETED FORM.

Your signature below authorizes us to release information and receive payment from your insurance company for those services received from the physician and the assisting physician.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

SIGNED: _____

DATE: _____

REFERRING PHYSICIAN: _____