

PEDIATRIC OPHTHALMOLOGY CONSULTANTS OF SOUTH FLORIDA, P.A.
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PLEASE PRINT

PATIENT'S NAME: _____ MALE: _____
FEMALE: _____
First Middle Last Nickname
SS#: _____-_____-_____
AGE: ____ BIRTH DATE: ____/____/____ HOME PHONE NUMBER: (____) ____-_____
ADDRESS: _____ APARTMENT NUMBER: _____
CITY: _____ STATE: _____ ZIP CODE: _____

MOTHER'S NAME: _____ SS#: _____-_____-_____
AGE: ____ BIRTH DATE: ____/____/____ BUSINESS PHONE NUMBER: (____) ____-_____
ADDRESS: _____ APARTMENT NUMBER: _____
CITY: _____ STATE: _____ ZIP CODE: _____

FATHER'S NAME: _____ SS#: _____-_____-_____
AGE: ____ BIRTH DATE: ____/____/____ BUSINESS PHONE NUMBER: (____) ____-_____
ADDRESS: _____ APARTMENT NUMBER: _____
CITY: _____ STATE: _____ ZIP CODE: _____

NEAREST RELATIVE OTHER THAN PARENTS: _____
ADDRESS: _____ PHONE NUMBER: (____) ____-_____
CITY: _____ STATE: _____ ZIP CODE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____
POLICY HOLDER: _____ SS#: _____-_____-_____
GROUP NUMBER: _____ CONTROL/POLICY NUMBER: _____
INSURANCE ADDRESS: _____
INSURANCE PHONE NUMBER: (____) ____-_____
SECONDARY INSURANCE NAME: _____

POLICY HOLDER: _____ SS#: _____-_____-_____
GROUP NUMBER: _____ CONTROL/POLICY NUMBER: _____
INSURANCE ADDRESS: _____
INSURANCE PHONE NUMBER: (____) ____-_____
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.

SIGNED: _____

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

DATE: _____

REFERRING PHYSICIAN:
