PATIENT INFORMATION						
NAME (Last, First)	MIDDLE NAME	SSN#	BIRTH DATE	LANGUAGE	SEX	
ADDRESS	CITY, STATE, ZIP	MARITAL STATUS	ETHNICITY	CURRENT GENDER		
PRIMARY PHONE	SECONDARY PHONE	EMAIL ADDRESS				
REFERRING PHYSICIAN	TEL#					
PRIMARY CARE PHYSICIAN	TEL#	PHARMACY	ADDRESS, TEL #			

PARENT INFORMATION			
NAME (Last, First, Middle)	BIRTH DATE	LANGUAGE	SEX
ADDRESS	CITY, STATE, ZIP	PHONE	
RELATIONSHIP TO PATIENT	EMAIL ADDRESS		
NAME (Last, First, Middle)	BIRTHDATE	LANGUAGE	SEX
ADDRESS	CITY,STATE, ZIP	PHONE	
RELATIONSHIP TO PATIENT	EMAIL ADDRESS		

PRIMARY INSURANCE	
NAME OF THE INSURANCE COMPANY	POLICY#
NAME OF INSURED	GROUP#

SECONDARY INSURANCE (If Applicable)	
NAME OF THE INSURANCE COMPANY	POLICY#
NAME OF INSURED	GROUP#

I, the undersigned, authorize Connecticut Eye Consultants, PC to bill my insurance company for services rendered, and to release information as requested by the insurance in order to process my bill. I understand **I AM RESPONSIBLE FOR OBTAINING A REFERRAL IF REQUIRED BY MY INSURANCE. I UNDERSTAND I AM RESPONSIBLE FOR ALL BALANCES ASSOCIATED WITH NON-COVERED CHARGES, DEDUCTIBLES AND CO-INSURANCES AS DICTATED BY MY INSURANCE PLAN**. I acknowledge full responsibility for all balances including no-show fees and fees incurred by Connecticut Eye Consultants in an attempt to collect those balances.

_____ SIGNATURE OF PARENT//GUARDIAN

_____ DATE