Wallace Eye Center
211 McAuley Court
Hot Springs, AR 71913

Children's Registration Form

This clinic accepts assignment on Medicare and Medicaid patients. All patients are expected to pay for non-covered services, their portion and the applicable copay on the date of service unless prior arrangements have been made. Thank you for your cooperation.

Patient's name: _____ Date of Birth: _____
First Middle initial Last Age: _____

Address: _____ Telephone ( ) _____
Street or P.O. Box City State Zip code

Male ☐ Female ☐ Social Security no. (optional) _____

Mother: _____ Telephone ( ) _____
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Social Security no. (optional) _____
Employer: _____ Work Telephone ( ) _____ Ext: _____
Address: _____ City: _____ State: _____ Zip: _____

Father: _____ Telephone ( ) _____
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Social Security no. (optional) _____
Employer: _____ Work Telephone ( ) _____ Ext: _____
Address: _____ City: _____ State: _____ Zip: _____

Please provide us with the name and telephone number of a friend or relative at a different address that we can contact in the event we are unable to reach you.
Name: _____ Telephone: ( ) _____ Ext: _____

Insurance Information: Please provide us with current insurance card(s) so that we can make copies.

Referred by: _____

I hereby authorize the release of any information concerning my exam or treatment for insurance purposes only.

X _____

I hereby authorize payment directly to the physician.

X _____

Today's date: _____

Please read the statements above and sign in both places if applicable. You can refuse to sign this acknowledgement.