Associated Ophthalmologists
Dr. David Morimoto Dr. Aras Zlioba
219 N. Hammes Avenue
Joliet, Illinois 60435

MINOR REGISTRATION FORM

Patient Last name: _____ **First Name:** _____ **Sex:** Male/Female

Date of Birth: _____ **SS #:** _____ **Phone:** _____

Address: _____

City: _____ State: _____ Zip: _____

Pediatrician/ Primary Care Physician: _____ Referring Physician: _____

Parent Information

Mother's Name: _____ **DOB:** _____ **SS#:** _____

Home #: _____ Work #: _____ Cell#: _____

Employer Name: _____ Address _____

Address: _____

City: _____ State: _____ Zip: _____

Father's Name: _____ **DOB:** _____ **SS#:** _____

Home #: _____ Work #: _____ Cell#: _____

Employer Name: _____ Address _____

Address: _____

City: _____ State: _____ Zip: _____

Legal Guardian: _____

PARENT BRINGING CHILD FOR APPOINMENT WILL BE RESPONSIBLE FOR CHARGES

Insurance Information

Primary Insurance: _____ ID Number: _____ Group# _____

Insured Last Name: _____ First Name: _____ DOB: _____

SS# _____ Insured Relationship to Patient: _____

Secondary Insurance: _____ ID Number: _____ Group# _____

Insured Last Name: _____ First Name: _____ DOB: _____

SS# _____ Insured Relationship to Patient: _____

I hereby authorize and direct my insurance benefits to be paid directly to Associated Ophthalmologists. I also authorize the release of information regarding medical records. As the Parent/ Guardian of the above patient. I consent to treatment of the said patient. I understand I am financially responsible for any fees incurred, including fees for medical services not covered by my insurance. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered and valid as the original.

Signed: _____ Date: _____

Relationship to Patient: _____