BERG·FEINFIELD
VISION CORRECTION

Pediatric/Strabismus Patient Information Form

Talia Kolin, M.D.

Today's Date: ______________________________

Patient's Information:

Name: ______________________________
Address: ______________________________
City, State, ZIP: ______________________________
Home Phone: ______________________________
Work Phone: ______________________________
Referred By: ______________________________

Eye Color: ____________________ Sex: ________
Birthdate: ______/______ /________ Age: ________
Patient's Insurance: ______________________________
Social Security # ______________________________
Med-Cal # ______________________________
Patient's Physician ______________________________

Responsible Party:

Name: ______________________________
Address(if different): ______________________________
City, State, ZIP: ______________________________
Birthdate: ______/______ /________
Social Security: ______________________________
Driver's License: ______________________________
Employer: ______________________________
Address: ______________________________
City, State, ZIP: ______________________________
Phone: (________)______________________________
Insurance: ______________________________
Group: ______________________________
Policy #______________________________
Emergency Contact:
Name: ______________________________

Spouse:

Name: ______________________________
Address(if different): ______________________________
City, State, ZIP: ______________________________
Birthdate: ______/______ /________
Social Security: ______________________________
Driver's License: ______________________________
Employer: ______________________________
Address: ______________________________
City, State, ZIP: ______________________________
Phone: (________)______________________________
Insurance: ______________________________
Group: ______________________________
Policy # ______________________________

Phone # (______)______________________________

At this office we require you to pay for services at the time of visit. If you have made other arrangements, please remember you are ultimately, responsible for payment. Please show your insurance card to our receptionist and Initial one of the methods of payment below:

How will you be paying for today's visit? ☐Cash ☐Check ☐HMO ☐MediCal ☐Other: ________________

HEALTH INFORMATION:

1. What is the patient's eye problem? ______________________________
2. Please describe any past eye problems ______________________________
   ____
3. Does the patient wear glasses? ☐ YES ☐ NO
4. Does the patient have any medical problems? ________If yes explain______________________________
   ____
5. List medications patient is currently taking: ______________________________
6. Please list any allergies the patient may have ______________________________
7. Do any members of the family have any eye problems (which members and what problems) ______
   ____
8. Which members of the immediate family wear glasses? ______________________________
9. Are there any members of the family with significant medical problems such as diabetes or hypertension? ______________________________

BILLING INFORMATION

NON-INSURED PATIENTS:

If you are not insured, it is our office policy here at **Berg•Feinfield Vision Correction** that payment is due at the time services are rendered unless a prior payment arrangement has been made.
I understand that I am financially responsible for payment of all charges incurred for services received from the doctor's office.

____

Signature of Patient/Guardian if Minor Date

INSURED PATIENTS:

I, the undersigned certify that I (or my dependent) have insurance coverage with:

____

Name of Insurance Company (ies)

I directly assign **Berg•Feinfield Vision Correction** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible of all charges incurred for services received from the doctor's office whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.