Stephen B. Prepas, M.D. A Medical Corporation
Eye Physician and Surgeon, Pediatric Ophthalmology and Strabismus
360 San Miguel Ave., Suite 407
Newport Beach, CA 92660
Phone (949) 644-7026 Fax (949) 644-7029

Child Patient Information Form

Patient Name: _____ Sex: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ SS# _____ Allergies: _____

Patient Resides with: (circle one) Mother Father Both Other: _____

Referred By: _____ Address/Phone: _____

General M.D.: _____ Address/Phone: _____

Nearest Relative: _____ Address/Phone: _____

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

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Phone: _____ Cell Phone: _____

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

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Phone: _____ Cell Phone: _____

Insurance Information

Primary Insurance Company: _____

Subscriber's Name: _____ SS#/ID#: _____

Secondary Insurance Company: _____

Subscriber's Name: _____ SS#/ID#: _____

Assignment/ Financial Agreement Information Release

The undersigned authorizes direct payment to Stephen B. Prepas, M.D., A Medical Corporation of any insurance benefits otherwise payable to or on behalf of the undersigned for these physician services. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

The undersigned agrees that to the extent necessary to determine liability for payment, the physician may disclose portions of the patient's records, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of the physician's charges including but not limited to insurance companies, health care service plans or Worker's Compensation carriers.

The undersigned certifies that he/she has read the foregoing and is the patient, patient's legal representative, or it duly authorized by the patient as the patient's general agent to execute the above and accept the terms. The undersigned may receive a copy of this upon request.

Date: _____ Signature: _____ Relationship: _____
(If not the patient)