

**ADDITIONAL INFORMATION
IF PATIENT IS A CHILD OR MINOR**

Child's Mother: _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Home # () _____ Cell # () _____ Work # () _____

Mother's Employer _____

Address _____ City _____ State _____ Zip Code _____

Child's Father: _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Home # () _____ Cell # () _____ Work # () _____

Father's Employer _____

Address _____ City _____ State _____ Zip Code _____

Are parents married? _____ Yes _____ No Are parents separated? _____ Yes _____ No

Who is financially responsible for this child? _____

Relationship: _____ Address (if different than parents) _____

City _____ State _____ Zip _____ Phone # () _____

INSURANCE INFORMATION: (If different than information on reverse side)

Who is the insurance coverage thru, mother or father or both? _____

Which is primary? _____

Mother's insurance _____ ID# _____

Father's insurance _____ ID# _____

Authorization – PLEASE READ BEFORE SIGNING

To process my medical claims for payment, I, _____, hereby authorize Ludwick Eye Center or their authorized agents, to release copies of my medical records and/or provide information regarding my physical or mental condition and treatment rendered to my insurance carrier and/or any agent acting on the insurance carrier's behalf. I understand that these records and/or information may include information regarding HIV, psychiatric/psychotherapy, mental health and or drug and/or alcohol information or treatment records, and I authorize the release of such records and/or information to my insurance carrier and/or any agent acting on the insurance carrier's behalf.

I also authorize Ludwick Eye Center to release copies of my medical records to include the above-mentioned records and/or information to my primary care, family or other treating physicians and optometrists.

I understand that if this is a workers' compensation claim the insurance carrier may employ a rehabilitation or consulting firm to handle my case. I authorize release of the above-mentioned records and/or information to the workers' compensation insurance carrier and/or the rehabilitation or consulting firm.

I hereby assign to Ludwick Eye Center all payments for medical services rendered to myself and/or my dependents, and I understand and agree that any services not covered by my insurance carrier are my financial responsibility.

Signature of patient/parent/legal representative: _____ Date: _____