Children's Registration Form

Gabrielle Family Vision Care 11411 NE 124th St., Bldg A, Ste 118 Kirkland, WA 98034 Ph 425.820.2143 Fax 425.820.2006
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Neena Gabrielle, O.D., FCOVD

Child's Name (LAST, First) ______ ❑ ________ ❑ Female ❑ Male
❑ Preferred Pronouns ______________________

Child's Nickname Birthday (Month/Day/Year)

Street Address City State Zip

Home Phone #

Name of Parent 1	Name of Parent 2
Relationship to Patient	Relationship to Patient
Address of Parent 1	Address of Parent 2
Employer/Occupation of Parent 1	Employer/Occupation of Parent 2
Work Phone # of Parent 1	Work Phone # of Parent 2
Cell Phone # of Parent 1	Cell Phone # of Parent 2
Email of Parent 1	Email of Parent 2

Does child live with: Both Parents ❑ Parent 1 ❑ Parent 2 ❑ Other ❑

Other family members seen in our office:

Who referred you to our office today?

Name: ______ ❑ MD/ND ❑ OT ❑ PT ❑ SLP ❑ Teacher/School ❑ Friend ❑ Family

Other: ❑ Insurance ❑ Advertisement (type) ______________________ ❑ Web Search ❑ Other

Primary Care Physician Information

Physician Name Phone Number

Clinic Name

Street Address City State Zip

Emergency Contact Information

Name: Relationship: Phone #

I hereby give Gabrielle Family Vision Care permission for my evaluation and treatment of my child. I hereby authorize the release of any medical or other information necessary to help process insurance claims when needed. When applicable, I also authorize payment directly to the doctor/clinic for any benefits available as a non-contract provider under my insurance plan. For any changes with scheduled appointments, **I understand that I must call 48 hours BEFORE to avoid a $150 cancel/no show charge**. I understand that I am financially responsible for any non-covered charges, processing fees and charges incurred by a collection agency in collecting any unpaid balances. **Returned checks are subject to returned check charge. For your convenience, we accept check, cash (if exact amount), Visa, MasterCard, American Express, Discover Card and debit cards. I understand that Dr. Neena Gabrielle is a non-contract provider for all insurance plans and the amount due for the visit is my responsibility**. **I understand the visit fee is due at time of service. I understand there are no refunds on services and all sales are final. I understand GFVC will not bill my insurance.** If not paid at time of service, I understand I will be charged late fees, processing fees, and collection fees. I understand that it is my responsibility to keep track of amounts needed to reach my deductible (if applicable). I understand that it is my responsiblity to obtain any referrals from my PCP as outlined by my insurance policy. I understand it is my responsibility to ask for any preauthorization as outlined by my insurance policy. I understand that it is my responsibility to contact my insurance company to review benefits and eligibility.

Signature of Resp. Party	Print Name of Resp Party	Date (M/D/Yr	Child Age	Child Grade	School Name	Staff Init.	Date (M/D/Yr)