

## 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  
 www.gabriellevision.com clinic@gabriellevision.com  
 Neena Gabrielle, O.D., FCOVD

Child's Name (LAST, First) \_\_\_\_\_ Female  Male

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

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_

Name of Parent 1	Name of Parent 2
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 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. 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 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 responsibility to obtain any referrals from my PCP as outlined by my insurance policy. I understand it is my responsibility to ask for any preauthorizations 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)