



PEDIATRIC PATIENT INFORMATION
PLEASE PRINT

NAME Last First MI Nickname SEX M F

ADDRESS Street Address/PO BOX # City State ZIP

TELEPHONE ()

PATIENT AGE BIRTH DATE SS#

EMERGENCY CONTACT (Other than Parents) PHONE # ()

PRIMARY DOCTOR/PEDIATRICIAN
PCP Clinic Name
Address Street Address/PO BOX #
City State ZIP
Phone # ()

If patient was referred, by whom?
IS THIS YOUR:
Primary caregiver Regular Eye Doctor
School Nurse Other

PARENT INFORMATION: If address and phone are same as patient check here

PARENT/GUARDIAN #1 SS# DATE OF BIRTH

PHONE # () ADDRESS Street Address/PO BOX # City State ZIP

EMPLOYER OCCUPATION

EMPLOYER PHONE # () OK to call this number?

PARENT/GUARDIAN #2 SS# DATE OF BIRTH

PHONE # () ADDRESS Street Address/PO BOX # City State ZIP

EMPLOYER OCCUPATION

EMPLOYER PHONE # () OK to call this number?

Person responsible for bill: SS#

PHONE # ADDRESS

INSURANCE INFORMATION (MUST BE COMPLETED IN ADDITION TO OBTAINING A COPY OF YOUR CARD)
Primary Insurance: Policyholder's Name
Secondary Insurance Policyholder's Name

Assignment of Benefits: I hereby assign to the physician all payments for medical services rendered to my dependents. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all the charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Parent or Guardian Signature Date

Reviewed Date Date Date Date Date Date