CHILDREN'S EYE CARE, PLLC
PATIENT INFORMATION
ALL INFORMATION MUST BE COMPLETED

Last name:_____ First name:_____ Middle Initial_____
Address:_____ City_____St_____Zip_____
Phone: (_____)_____ Date of birth: _____ Male Female
SSN: _____ Nickname:_____

Mother's last name:_____ First name:_____
Address:_____City_____St_____Zip_____
Phone: (_____)_____ Date of birth: _____
SSN: _____ Employer: _____
Work phone: (_____)_____ Address: _____
Cell / Pager: (_____)_____ City / St / Zip: _____

Mother's spouse (if other than patient's father)
Last name: _____ First name: _____
Address: _____ City _____
Phone: (_____)_____ Date of birth: _____
SSN: _____ Employer: _____
Work phone: (_____)_____ Address: _____
Cell / Pager: (_____)_____ City / St / Zip: _____

Father's last name: _____ First name: _____
Address: _____ City _____
Phone: (_____)_____ Date of birth: _____
SSN: _____ Employer: _____
Work phone: (_____)_____ Address: _____
Cell / Pager: (_____)_____ City / St / Zip: _____

Father's spouse (if other than patient's mother)
Last name: _____ First name: _____
Address: _____ City _____
Phone: (_____)_____ Date of birth: _____
SSN: _____ Employer: _____
Work phone: (_____)_____ Address: _____
Cell / Pager: (_____)_____ City / St / Zip: _____

Emergency contact:
Last name: _____ First name: _____
Address: _____City _____ St _____ Zip_____
Relationship: _____Phone: (_____)_____
Work phone: (_____)_____Cell / Pager: (_____)_____

Referring physician: _____

Current pediatrician: _____

AUTHORIZATION OF BENEFITS AND RELEASE OF INFORMATION
I hereby authorize payments for this medical and/or surgical benefit to be made directly to Children's Eye Care, PLLC. I understand I am responsible for any portion of my bill not covered by my insurance company. I also authorize release of information for insurance claim purposes.

Signature: _____ Date: _____