PATIENT REGISTRATION

Please Print (Pen Only)

Children's Eye Clinic, PC
6000 University Avenue, Suite 210
West Des Moines, IA 50266-8200
Ph. 515-222-1180 Fax 515-222-9635

Child's Name______________________________ **Child's Date of Birth**____________
First Initial Last

Home Address______________________________ **Sex:** M F

City, State & Zip Code______________________________ **Child's Primary Doctor**____________

PRIMARY PHONE # (____)______________________________ **Child's Social Security #**____________

Alternate Contact (Other than Parent) ______________________________

Contact's Phone Number (_____)______________________________ Relationship to Child____________

Parent's Information

Circle One Father Stepfather Foster Parent Guardian	**Circle One** Mother Stepmother Foster Parent Guardian
Name ____________ ______ ____________	Name____________ ______ ____________
Address, if different than child's: ____________	Address, if different than child's:____________
Home Telephone (_____)____________	Home Telephone (_____)____________
Cell Phone (______)____________	Cell Phone (_______)____________
Social Security Number____________	Social Security Number____________
Date of Birth____________	Date of Birth____________
Employer____________	Employer____________
Occupation____________	Occupation____________
Work Telephone (_____)____________	Work Telephone (____)____________

Marital Status of Parents **Circle One** Single Married Divorced Separated Widowed

Custody: Both Parents Father Mother Other____________ Child Lives with____________

Financial Information

Primary Medical Ins____________ Member ID#____________ Group #____________

Primary Policy Holder's Name____________ DOB____________ Social Security ____________

Insurance Address:______________________________

Secondary Medical Ins____________ Member ID#____________ Group #____________

Secondary Policy Holder's Name____________ DOB____________ Social Security ____________

Insurance address:______________________________

Person Responsible for the Account____________ Relationship to child____________

Signature of Parent/Guardian____________ **Date Completed**____________

Print Name of Parent/Guardian____________

UPDATED: 09/04/14