

**PATIENT REGISTRATION**

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

**Please Print** (Black Ink Only)

**Child's Name** \_\_\_\_\_

**Child's Date of Birth** \_\_\_\_\_

Home Address \_\_\_\_\_

**Sex:** M F

City, State & Zip Code \_\_\_\_\_

Child's Social Security Number \_\_\_\_\_

Home Phone Number (\_\_\_\_) \_\_\_\_\_

Name of Contact Person (Other than Parent) \_\_\_\_\_

Contact's Relationship to **Child** \_\_\_\_\_

Contact's Phone Number (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

City, State and Zip Code \_\_\_\_\_

**Father's Information**

**Mother's Information**

**Circle One** Father Steppather Foster Father

**Circle One** Mother Stepmother Foster Mother

Name \_\_\_\_\_

Name \_\_\_\_\_

Address, if different than child's:

Address, if different than child's:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Home Telephone (\_\_\_\_) \_\_\_\_\_

Home Telephone (\_\_\_\_) \_\_\_\_\_

Social Security Number \_\_\_\_\_

Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_

Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Occupation \_\_\_\_\_

Work Telephone (\_\_\_\_) \_\_\_\_\_

Work Telephone (\_\_\_\_) \_\_\_\_\_

Cell Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

E-Mail \_\_\_\_\_

E-Mail \_\_\_\_\_

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

Custody: Both Parents Father Mother Other \_\_\_\_\_ Child Lives with \_\_\_\_\_

**Financial Information**

Person Responsible for the Account \_\_\_\_\_

Primary Medical Ins \_\_\_\_\_

Primary Policy Holder's Name \_\_\_\_\_ DOB \_\_\_\_\_ Social Security \_\_\_\_\_

Secondary Medical Insurance \_\_\_\_\_

Secondary Policy Holder's Name \_\_\_\_\_ DOB \_\_\_\_\_ Social Security \_\_\_\_\_

**Signature of Parent/Guardian** \_\_\_\_\_

Date Completed \_\_\_\_\_

Print Name of Parent/Guardian \_\_\_\_\_

**THANK YOU!**