FAMILY EYE CARE CHILDREN'S EYE CENTER
OF NEW MEXICO

Today's Date:

Pediatric Registration Form

PATIENT INFORMATION				
LAST NAME		FIRST NAME		MIDDLE INITIAL
ADDRESS		CITY	STATE	ZIP
AGE	DATE OF BIRTH	WHO REFERRED YOUR CHILD TO US? WHO IS YOUR CHILD'S CHILD TO OUR OFFICE?	❑ FEMALE ❑ MALE	WHO IS YOUR CHILD'S PRIMARY CARE PROVIDER (PCP)?

PARENT OR LEGAL GUARDIAN INFORMATION			
LAST NAME	FIRST NAME		MIDDLE INITIAL
ADDRESS ❍ SAME AS ABOVE	CITY	STATE	ZIP
OCCUPATION	EMPLOYER	WORK PHONE	
HOME PHONE	CELL PHONE	E-MAIL	
THE PERSON LISTED ABOVE IS THE CHILD'S: ❑ BIOLOGICAL PARENT ❑ ADOPTIVE PARENT ❑ LEGAL GUARDIAN ❑ FOSTER PARENT ❑ OTHER:			

PARENT OR LEGAL GUARDIAN INFORMATION			
LAST NAME	FIRST NAME		MIDDLE INITIAL
ADDRESS ❍ SAME AS ABOVE	CITY	STATE	ZIP
OCCUPATION	EMPLOYER	WORK PHONE	
HOME PHONE	CELL PHONE	E-MAIL	
THE PERSON LISTED ABOVE IS THE CHILD'S: ❑ BIOLOGICAL PARENT ❑ ADOPTIVE PARENT ❑ LEGAL GUARDIAN ❑ FOSTER PARENT ❑ OTHER:			

BILLING INFORMATION	
PERSON RESPONSIBLE FOR PAYMENT OF BILL	RELATIONSHIP TO PATIENT

ADDRESS	CITY	STATE	ZIP

INSURANCE COMPANY	SUBSCRIBER	RELATIONSHIP TO PATIENT

NAME AND SIGNATURE OF PERSON COMPLETING THIS FORM:

DATE:

REG020913

PLEASE COMPLETE BACK OF FORM

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OF NEW MEXICO

Pediatric Health History

PATIENT INFORMATION			
LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH

CURRENT HEALTH STATUS AND HEALTH HISTORY

BIRTH AND DEVELOPMENTAL HISTORY

❑ PREMATURE ❑ FULL TERM _____ POUNDS _____ OUNCES

IS YOUR CHILD'S GROWTH AND DEVELOPMENT NORMAL?
❑ YES ❑ NO

CHILD'S GRADE LEVEL:

SCHOOL PERFORMANCE:

DESCRIBE ANY PROBLEMS DURING PREGNANCY, LABOR, DELIVERY, OR AFTER YOUR CHILD'S BIRTH:

DOES YOUR CHILD WEAR GLASSES? ❑ YES ❑ NO
DOES YOUR CHILD WEAR CONTACT LENSES? ❑ YES ❑ NO
HAS YOUR CHILD EVERY HAD AN EYE INJURY? ❑ YES ❑ NO

ALLERGIES ❑ NONE KNOWN ❑ YES (PLEASE LIST BELOW)

PLEASE LIST CURRENT HEALTH PROBLEMS:

PLEASE LIST ANY OTHER EYE PROBLEMS:

MEDICATIONS		PREVIOUS SURGERIES	
MEDICATION	DOSE AND FREQUENCY	SURGERY	YEAR
