FAMILY EYE CARE CHILDREN'S EYE CENTER
OF NEW MEXICO

Pediatric Registration Form

Today's Date:

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

ADDRESS	CITY	STATE	ZIP

AGE	DATE OF BIRTH	WHO REFERRED YOUR CHILD TO US?	❑ FEMALE ❑ MALE	WHO IS YOUR CHILD'S PRIMARY CARE PROVIDER (PCP)?

PARENT OR LEGAL GUARDIAN INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

ADDRESS	CITY	STATE	ZIP

❑ SAME AS ABOVE

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:

LAST NAME	FIRST NAME	MIDDLE INITIAL

ADDRESS	CITY	STATE	ZIP

❑ SAME AS ABOVE

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:

PLEASE COMPLETE BACK OF FORM ➡

FAMILY EYE CARE CHILDREN'S EYE CENTER OF NEW MEXICO

Pediatric Health History

PATIENT INFORMATION

LAST NAME | FIRST NAME | MIDDLE INITIAL | DATE OF BIRTH

BILLING INFORMATION

PERSON RESPONSIBLE FOR PAYMENT OF BILL | RELATIONSHIP TO PATIENT

ADDRESS | CITY | STATE | ZIP

INSURANCE COMPANY | SUBSCRIBER | RELATIONSHIP TO PATIENT

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

MEDICATION	DOSE AND FREQUENCY

PREVIOUS SURGERIES

SURGERY	YEAR

NAME AND SIGNATURE OF PERSON COMPLETING THIS FORM: DATE: