Asst. Initials _____

PEDIATRIC PATIENT INFORMATION FORM

All information required. If not applicable, please write N/A.
PLEASE PRINT / WRITE LEGIBLY.

Patient Last Name: _____ **First Name:** _____ **MI:** _____

Address: _____
Street Address/PO Box # City State Zip

Patient Home Phone: (____) _____ **Patient Age:** ____ **Date of Birth:** _____ ☐ **Male** ☐ **Female**

Parent Email ***(required)*****:** _____ **Patient SS#:** _____

*We abide by all HIPAA privacy regulations and do not sell or market your demographic information, including your e-mail address, to anyone.

Parent #1: _____ **Date of Birth:** _____ **Soc Sec #:** _____

Home Phone: (____) _____ **Cell Phone**, ***if different than home*****:** (____) _____

Employer: _____ **Employer Phone:** (____) _____

Parent #2: _____ **Date of Birth:** _____ **Soc Sec #:** _____

Home Phone: (____) _____ **Cell Phone**, ***if different than home*****:** (____) _____

Employer: _____ **Employer Phone:** (____) _____

Other Guardian: _____ **Date of Birth:** _____ **Soc Sec #:** _____

Home Phone: (____) _____ **Cell Phone**, ***if different than home*****:** (____) _____

Employer: _____ **Employer Phone:** (____) _____

Primary Medical Caregiver (PCP): First Name: _____ **Last Name:** _____ **Clinic Name:** _____

Address: _____ **Phone:** (____) _____

Pharmacy: _____
City State

INSURANCE INFORMATION:

Primary Insurance: _____ **Policyholder's Name:** _____

Policyholder's ID#: _____ **Group#:** _____

Secondary Insurance: _____ **Policyholder's Name:** _____

Policyholder's ID#: _____ **Group#:** _____

Work Related: Yes / No **Date of Injury:** _____ **L&I Carrier:** _____

Emergency Contact: _____ **Emergency Phone:** (____) _____

Assignment of Benefits: I hereby assign payment of medical and/or surgical benefits be made to me or on my behalf to Spokane Eye Clinic for any services furnished to the patient by that facility. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I authorize Spokane Eye Clinic to release any medical information which may be required to determine benefits or process claims through my insurance carrier. I understand I am responsible to pay for all services provided to the patient, whether the insurance company makes payment or not.

Custodial Parent or Guardian Signature: _____ **Date**: _____