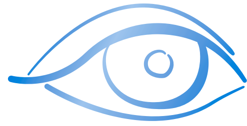

HEATON
EYE ASSOCIATES
Come See The Difference

CHILD PATIENT INFORMATION

Child's Last Name:	Child's First Name:	Middle Initial:	
DOB:	Age:	☐ Male ☐ Female	SS#:
Address:	City:	State:	Zip:

Mother/Guardian:	Home Phone:	Cell Phone:	
Address:	City:	State:	Zip:
DOB:	SS#:	Marital Status *(circle one)*: Single / Mar / Div / Sep / Wid	
Email:	Home Phone:	Cell Phone:	
Employer:	Employer Address:		

Father/Guardian:	Home Phone:	Cell Phone:	
Address:	City:	State:	Zip:
DOB:	SS#:	Marital Status *(circle one)*: Single / Mar / Div / Sep / Wid	
Email:	Home Phone:	Cell Phone:	
Employer:	Employer Address:		

Emergency Contact & Phone *(friend/relative living at different address)*:

Primary Insurance:	
Policy Holder:	Policy Number:
Other Insurance:	
Policy Holder:	Policy Number:
Here for a worker's compensation injury? ☐ No ☐ Yes,	Date of Injury:
Employer's Address:	Contact Person at Work & Phone:
I declare I have no other insurance than what is listed *(sign & date)*	

Race/Ethnicity: ☐ Hispanic/Latino ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other *(please list)*:	
Preferred Language: ☐ English ☐ Other *(please list)*:	
Referring Optometrist:	Primary Care Physician (PCP):
I am interested in learning more about: ☐ LASIK ☐ Getting Out of Glasses ☐ Cosmetic Procedures and/or BOTOX	

PLEASE BRING YOUR INSURANCE CARDS AND DRIVER'S LICENSE TO THE FRONT DESK.