G. Gregory Clark, M.D. Anne C. Clark, M.D. Frances M. Cosgrove, M.D.

EYE ASSOCIATES LLC

PEDIATRIC PATIENT REGISTRATION

PATIENT INFORMATION

DATE _____

NAME: _____ MALE FEMALE (circle one)

AGE: _____ BIRTH DATE: _____ SSN: _____

RACE: _____ ETHNICITY: _____ PREFERRED LANGUAGE: _____

NAME OF PERSON WITH WHOM PATIENT RESIDES: _____

PRIMARY CARE PHYSICIAN: _____ ADDRESS: _____ PH: _____

WHO REFERRED YOU TO EYE ASSOCIATES: _____

PREFERRED PHARMACY: _____ PH: _____

MOTHER'S NAME: _____

ADDRESS: _____

MARITAL STATUS:
☐Married ☐Single
☐Divorced ☐Widowed

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PH: _____ WORK PH: _____ CELL PH: _____

PLACE OF EMPLOYMENT: _____ PREFERRED EMAIL: _____

FATHER'S NAME: _____

ADDRESS: _____

MARITAL STATUS:
☐Married ☐Single
☐Divorced ☐Widowed

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PH: _____ WORK PH: _____ CELL PH: _____

PLACE OF EMPLOYMENT: _____ PREFERRED EMAIL: _____

NAME OF RELATIVE OR FRIEND NOT LIVING WITH YOU: _____ PH: _____

LIST ANY OTHER FAMILY MEMBERS THAT ARE EYE ASSOCIATES PATIENTS: _____

PRIMARY INSURED OR GUARDIAN FIANCIALLY RESPONSIBLE: _____ SSN: _____

RELATION TO PATIENT: _____ BIRTH DATE: _____

DOES PATIENT HAVE INSURANCE COVERAGE (circle one): YES NO

PRIMARY INSURANCE:

INSURANCE COMPANY: _____ NAME: _____ MALE FEMALE (circle one)

POLICY HOLDER'S DATE OF BIRTH: _____ POLICY HOLDER'S SSN: _____

POLICY HOLDER'S EMPLOYER: _____

SECONDARY INSURANCE:

INSURANCE COMPANY: _____ NAME: _____ MALE FEMALE (circle one)

POLICY HOLDER'S DATE OF BIRTH: _____ POLICY HOLDER'S SSN: _____

POLICY HOLDER'S EMPLOYER: _____

SIGNATURE _____ DATE _____