FAMILY FOCUS EYECARE

New Patient Registration

All information contained within this form is strictly confidential.
Please complete this document prior to your first appointment.

Children's Form

Patient Information	Parent Information
First Name _____	Mother's Name _____
Last Name _____ Middle Initial _____	Father's Name _____
Gender _____ Birth Date _____	Parent's Address (If different from previous):
Patient's SSN _____	_____
Home Address _____	_____
Suite/Apt. _____	Parent's SSN _____ Parent's DOB _____
City _____ State _____ Zip Code _____	Primary Phone # _____
School _____ Grade _____	Home ☐ Cell ☐ Work ☐
Is your child in an age appropriate grade? ☐ Yes ☐ No	Secondary Phone # _____
Who is financially responsible for this account?	Home ☐ Cell ☐ Work ☐
_____	E-Mail _____

Race (Optional)	Ethnicity (Optional)
☐ American Indian or Alaskan Native ☐ Black or African American ☐ Asian	☐ Hispanic or Latino ☐ Decline
☐ Native Hawaiian or Other Pacific Islander ☐ White or Caucasian ☐ Decline	☐ Not Hispanic or Latino
☐ Other _____	Preferred Language _____

Reason for Visit

Date of last eye exam _____ Former Optometrist _____

What is your main reason for visit? _____

Has your child's teacher notified you of any concerns regarding your child's performance in school? ☐ Yes ☐ No

Do you feel your child is performing up to their potential in their schoolwork? ☐ Yes ☐ No

Does your child have any coordination or balance problems? ☐ Yes ☐ No

Does your child play sports? ☐ Yes ☐ No If yes, what sports is he or she involved in? _____

Insurance Policy Holder Information	Where did you hear about our office?
Vision Insurance Provider _____	☐ Referred by your doctor
Medical Insurance Provider _____	☐ Visited our website
Policy Holder Name _____	☐ Found us on social media
Member's Date of Birth _____ Member's SSN _____	☐ TV Commercial
Member's Phone # _____ ☐ Cell ☐ Home ☐ Work	☐ Printed Publication
Member's Address (if different from above):	☐ Referred by _____
_____	☐ Other _____