Heartland Eye Consultants
Pediatric Patient Demographics

Patient:
Last Name:_____First Name:_____ M.I._____

Street Address:_____Apt #_____ Gender: M F **Date of Birth**:___/___/_____

City: _____ State:_____ Zip Code:_____Soc. Sec. No. ____-____-_____ **Age** _____

Which doctor referred you to our office?_____ If not, please list_____

Who performed your last eye exam? _____ Date: ____/____/____

Pediatrician/Family Physician: _____M.D.

Name of Emergency Contact:_____ Relationship:_____Phone:_____
(Not living in household) (Area Code)

Please place an X in the boxes to indicate with whom the child lives:
☐**Father's Last Name**:_____**First Name**:_____ M.I.____ Birthdate: ____/____/_____

Address _____ City:_____ State:____ Zip Code:_____
If we need to contact you to confirm or change an appointment, which method(s) do you prefer? (Please place an X in the circle.)
○Cell Phone: (___)_____ ○Home Phone:(____)_____ ○Email Address: _____

SSN:_____ Employer: _____Occupation_____Title: _____ __

Employer's Address:_____ City_____State_____Zip_____○Work Phone_____

☐**Mother's Last Name**:_____**First Name**:_____ M.I.____ Birthdate: ____/____/_____

Address _____ City:_____ State:____ Zip Code:_____ **If we need to contact you to confirm or change an appointment, which method(s) do you prefer? (Please place an X in the circle.)**
○Cell Phone: (___)_____ ○Home Phone: (___)_____ ○Email Address: _____

SSN:_____ Employer: _____ Occupation_____Title: _____

Employer's Address:_____ City_____State_____Zip_____○Work Phone_____

☐Step-Father's Last Name: _____ First Name:_____M.I.___ Birthdate: ____/____/___

☐Step-Mother's Last Name: _____ First Name:_____M.I.___ Birthdate: ____/____/___

The person requesting services for a minor is the responsible party.

We will file major medical insurance coverage for you if you provide us with a copy of your current card. For patients without insurance coverage, you will be responsible for payment today by cash, check or credit card. (We accept MasterCard or Visa.)

Photo Release:
I hereby grant Heartland Eye Consultants, L.L.C. and Developmental Vision Associates, P.C. permission to have my child's photograph taken for patient information. This does not allow them to use my child's likeness in photographs and/or video in any of its publications or media.

AUTHORIZATION TO RELEASE INFORMATION TO YOU INSURANCE COMPANY AND ACKNOWLEDGEMENT OF PERSONAL RESPONSIBILITY FOR PAYMENT

I hereby assign all medical benefits (to which my child is entitled) to the doctor caring for my child. This includes major medical benefits, Medicare, Medicaid, private insurance and any health plans in which I am enrolled. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize the holder of my medical and patient registration records to release any information need to process my insurance claims. I understand that I am the guarantor of this account.

A copy of my child's medical records can be requested in writing and will be provided to me or whomever I designate for $15.00. There is a $25.00 fee for returned checks.

Authorized Signature: _____Date of Signature: _____