PEDIATRIC EYE CARE & SURGERY
Sarah J. Whang, M.D.

PATIENT REGISTRATION

Child's Name_____ **Child's Date of Birth**_____

Home Address_____ Child's Age_____

City, State & Zip Code_____ Sex: M F

Home Phone #_____Name(s) of any family member(s) treated in this office_____

Father's Information

Circle One: Father Stepfather Foster Father

Name_____

Address, if different than child's

_____

_____

Home Telephone (____)_____

Social Security #_____

Driver's License #_____

Date of Birth_____

Employer_____

Occupation_____

Work Telephone_____

Cell Phone_____

E-Mail_____

Mother's Information

Circle One: Mother Stepmother Foster Mother

Name_____

Address, if different than child's

_____

_____

Home Telephone (____)_____

Social Security #_____

Driver's License #_____

Date of Birth_____

Employer_____

Occupation_____

Work Telephone_____

Cell Phone_____

E-Mail_____

Marital Status of Parents **Circle One** Single Married Divorced Separated Widowed

Custody: Both Parents Father Mother Other_____Child Lives With_____

Name of Contact Person (Other than Parent)_____Contact's Relationship to **Child**_____

Contact's Phone # (____)_____

Address_____

City, State & Zip Code_____

Who referred you to our office?_____ Child's Physician_____

Financial Information

Insurance Co. (1)_____

Address_____

City, State & Zip Code_____

Phone #_____GR. #_____

Member Certificate No._____

Subscriber's Name_____

Insurance Co. (2)_____

Address_____

City, State & Zip Code_____

Phone #_____GR. #_____

Member Certificate No._____

Subscriber's Name_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I have received or have declined to receive a copy of the Notice of Privacy Practices.

_____ _____ _____

Signature of Responsible Person Relationship to Child Date