Children's Eye Care and Family Eye Care

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Contact Lenses

PATIENT INFORMATION

List family members previously seen here: _____

Name: _____ Birthdate: _____ Sex: M F
Last First MI

Address: _____

Social Security #: _____ Home Phone #: _____ Work #: _____

Primary Doctor's Name: _____ Doctor's Phone #: _____

Doctor's Address: _____

Doctor Type: ☐ Pediatrician ☐ Internal Medicine ☐ Family Practice ☐ Other: _____

PRIMARY INSURANCE

Insurance Company Name: _____ Phone #: _____

Primary Insured Name: _____ Birthdate: _____ Relationship to Pt: Self/Spouse/Parent

ID #: _____ Group #: _____ Copay: _____ Employer: _____

RESPONSIPLE PARTY/PARENT INFORMATION

Name: _____ Relationship to Pt: _____

Address (if different from above): _____ Home #: _____

Social Security #: _____ Work #: _____ Cell #: _____

Other Parent/Spouse Name: _____ Relationship to Pt: _____

Address (if different from above): _____ Home #: _____

Social Security #: _____ Work #: _____ Cell #: _____

PATIENT/FAMILY HEALTH INFORMATION

Who referred you to us? _____ Reason for exam: _____

Date of last eye exam: _____ Examiner's Name: _____

Does patient wear glasses/contacts? _____ Age at which eyewear began: _____

Is patient on daily or regular medication?: ☐ Yes ☐ No List medicine(s): _____

Is patient **ALLERGIC** to any medication?: ☐ Yes ☐ No List medicine(s): _____

List any past or present medical conditions: _____

_____

_____

FORM CONTINUED ON BACK

PATIENT/FAMILY HEALTH INFORMATION (continued)

Patient/Family History of Illness: (Include parents, grandparents, siblings, aunts, and uncles)

Crossed Eyes:	☐ Patient	☐ Family	☐ Other (state nature): _____
Lazy Eye:	☐ Patient	☐ Family	☐ Other: _____
Prematurity:	☐ Patient	☐ Family	☐ Other: _____
Glaucoma:	☐ Patient	☐ Family	☐ Other: _____
Blindness:	☐ Patient	☐ Family	☐ Other: _____
Heart Disease:	☐ Patient	☐ Family	☐ Other: _____
Diabetes:	☐ Patient	☐ Family	☐ Other: _____

CONSENT FOR TREATMENT

I hereby give consent to the physician and/or her designee(s) for treatment and for the administration of medication. I authorize you to give reasonable and proper medical care by today's standards. I understand that no guarantee or assurance has been made as to the results that may be obtained.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Children's Eye Care, L.L.C. to furnish my insurance company all information, which said company, may request concerning my medical condition or injury. I agree that photocopy of this, my original authorization, shall be considered equally authentic.

ASSIGNMENT OF BENEFITS

I, the undersigned, hereby authorize and assign payment of medical/vision benefits by my insurance company to Children's Eye Care, L.L.C., for services rendered.

FINANCIAL AGREEMENT

Office Visits: All fees including co-pays are to be paid upon completion of the office visit. Insurance claims will be submitted to those insurance companies in which Children's Eye Care, L.L.C. participates. If no payment has been received for 90 days after receipt of the insurance payment, the account will be transferred to a collection agency.

Surgery: The information listed above for office visits applies to surgery fees as well.

LEGAL ASSIGNMENT

I the undersigned, understand that I am financially responsible for those charges not paid by my insurance company.

The undersigned certifies that he/she has read the foregoing paragraphs and is the patient, parent, or guardian of the patient, or is duly authorized to execute and accept its terms.

_____	_____	_____
Print Patient Name	Patient/Responsible Party Signature	Date

_____

Witness