



**PATIENT INFORMATION**  
(please print)

Name: \_\_\_\_\_ also known as: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_ ☐ M ☐ F

Address: \_\_\_\_\_  
\_\_\_\_\_

Primary phone contact: \_\_\_\_\_ Owners Name: \_\_\_\_\_  
[ ] Home [ ] Cell [ ] Work

Secondary phone: \_\_\_\_\_ Owners Name: \_\_\_\_\_  
[ ] Home [ ] Cell [ ] Work

Email: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Practice: \_\_\_\_\_

**INSURANCE**

**Primary Insurance:**

Policy Owner: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ SS# \_\_\_\_\_

Policy #: \_\_\_\_\_ Group # \_\_\_\_\_

**Secondary Insurance:**

Policy Owner: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ SS# \_\_\_\_\_

Policy #: \_\_\_\_\_ Group # \_\_\_\_\_

**FOR PATIENTS UNDER 18 YEARS OF AGE**

**Guardian name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

[ ] Address/phone same as patient

Address: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ [ ] Home [ ] Cell [ ] Work

**Guardian name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

[ ] Address/phone same as patient

Address: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ [ ] Home [ ] Cell [ ] Work



**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**PLEASE BRING**  
**ALL INSURANCE CARD(S) AND PHOTO ID**  
**AND A LIST OF ALL CURRENT MEDICATIONS**  
**TO YOUR APPOINTMENT**

**ALL NEW PATIENTS UNDER 18 WILL BE DILATED AT THIS VISIT.**

**WOULD YOU LIKE ACCESS TO OUR PATIENT PORTAL WHICH GIVE YOU ACCESS TO  
A SUMMARY OF EACH CLINIC VISIT?**

☐ **YES**

☐ **NO**



**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

### **FINANCIAL RESPONSIBILITY AND WAIVER/RELEASE**

#### **Insurance**

I understand that it is the patient/parent responsibility to supply Children's Eye Specialists, LLC with any current insurance information and/or any referral authorization forms that may be necessary for my insurance claim.

I authorize all payments of services from all insurance carriers to be made to Children's Eye Specialists, LLC. I understand this Financial Responsibility and Waiver/Release form and agree that I am responsible for paying any amount not covered by my insurance plan. If this account results in collection agency involvement, the undersigned guarantor agrees to pay all legally allowed interest and associated fees.

I understand that most insurance carriers do NOT pay for all health care costs. Carriers only pay for covered benefits. Some items and services are not covered benefits and carriers will not pay for them. If I receive a service that is not a covered benefit, I will be financially responsible for payment. I also understand that I am responsible for all insurance deductibles, co-insurance, co-pays and any non-covered services at the time services are rendered.

#### **Conclusion**

Although our staff is very knowledgeable about insurance plans and policies, it is NOT our responsibility to know the details of individual plans. Your insurance is a contract between you and/or your employer and the insurance company; not with Children's Eye Specialists, LLC or the doctor. We do encourage you to speak with your insurance company BEFORE your scheduled appointment to review any specific details. We will do everything we can to be of assistance.

**I AM AWARE THAT I AM RESPONSIBLE FOR ANY UNPAID/OVERDUE BALANCES.**

\_\_\_\_\_  
**Signature of patient or guarantor**

\_\_\_\_\_  
**Date**

#### **Medical vs Vision Insurance**

Medical insurance DOES NOT cover any vision-related services (refraction or routine exams). Vision plans do not cover any medical testing, consultation or treatment. I understand that Children's Eye Specialists, LLC only bills through medical insurance and not vision policies.

Refraction is a measurement that is performed to establish a baseline of the patient's vision. It is the only way to determine whether or not the patient needs glasses. It is done at least once a year to monitor any changes. Refractions are required to establish the status of your vision. Your medical insurance will not cover this service. You can use your receipt to ask for reimbursement from your vision insurance. **Our fee is \$40.00 and is payable at the time of service.**

**IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. WE ACCEPT CASH, CHECK AND ALL MAJOR CREDIT/DEBIT CARDS.**



**CHILDREN'S EYE  
SPECIALISTS**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of patient or gurantor**

\_\_\_\_\_  
**Date**

**CONSENT FOR TREATMENT**

I AGREE AND GIVE CONSENT TO THE TREATING PHYSICIANS AND STAFF OF CHILDREN'S EYE SPECIALISTS. I CONSENT TO ALL TREATMENTS AND DIAGNOSTICS.

\_\_\_\_\_  
**Signature of patient or person medically responsible**

\_\_\_\_\_  
**Date**

**NOTICE OF PRIVACY PRACTICES**

The HIPPA Privacy Rule requires that health care providers distribute a notice that provides a clear, user friendly explanation of individuals' rights with respect to their personal health information and the privacy practices of health plans and health care providers. A full copy of this notice is available upon request and is also displayed in our lobby.

I have read the notice of privacy practices form and understand my rights. Any questions I may have, have been answered clearly and I understand my rights in the Notice. I authorize the release of medical information to other healthcare providers (i.e. primary care physician, hospitals, etc).

\_\_\_\_\_  
**Signature of patient or person medically responsible**

\_\_\_\_\_  
**Date**

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I can authorize other parties to have access to medical information that is not included in the Notice of Privacy Practices. There are other people that I will want to have access to my medical information in the case that I am not available or do not have the information they need. If there are any individuals listed below who should only have limited access to the information, I must document that next to their name. Otherwise, the individuals listed below can have full access to any of my medical information.

\_\_\_\_\_  
**Printed name**

\_\_\_\_\_  
**Relationship**

\_\_\_\_\_  
**Printed name**

\_\_\_\_\_  
**Relationship**

\_\_\_\_\_  
**Printed name**

\_\_\_\_\_  
**Relationship**



**CHILDREN'S EYE**  
SPECIALISTS

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

[ ] By checking this box, I would like NO information to be released to anyone.



**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Also Known As** \_\_\_\_\_

## **PATIENT MEDICAL HISTORY INFORMATION**

**REASON FOR VISIT:** \_\_\_\_\_

### **Patient History:**

Influenza/Pneumonia shot	<input type="checkbox"/>	Autism	<input type="checkbox"/>
Previous hospitalization	<input type="checkbox"/>	Recent illness	<input type="checkbox"/>
Developmental delay	<input type="checkbox"/>	Learning disorder	<input type="checkbox"/>
Genetic disorder	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>
Sickle Cell	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Hydrocephalus	<input type="checkbox"/>	Joint problems/arthritis	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	Psychiatric disorders	<input type="checkbox"/>
Cerebral palsy	<input type="checkbox"/>	Bleeding disorders	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Downs syndrome	<input type="checkbox"/>	Alcohol use	<input type="checkbox"/>
Thyroid condition	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>

Smoking status: ☐ Never ☐ former ☐ current ☐ second hand smoke

Occupation: \_\_\_\_\_

### **For patients 18 and under:**

Premature: ☐ No ☐ Yes – Gestational age: \_\_\_\_\_ wks Birth weight: \_\_\_\_\_ gms

Patient Lives with: ☐ Father ☐ Mother ☐ Siblings, how many? \_\_\_\_\_  
☐ Others \_\_\_\_\_

School grade: \_\_\_\_\_ School: \_\_\_\_\_



**CHILDREN'S EYE**  
SPECIALISTS

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Family History** - any blood relatives have:

	Relationship		Relationship
Blindness	_____	Childhood cataracts	_____
Amblyopia/lazy eye	_____	Childhood glaucoma	_____
Strabismus/eye misalignment	_____	Eye Cancer	_____
Nystagmus/jerking eyes	_____	Delayed development	_____
Glasses before age 6	_____	Other eye disease	_____
			_____

**Pediatrician/Primary:** \_\_\_\_\_ **Practice:** \_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_

Pharmacy Address/Phone: \_\_\_\_\_

**Eye History:**

Seen by other eye doctor: ☐ No ☐ Yes Name: \_\_\_\_\_

History of eye disease: ☐ No ☐ Yes \_\_\_\_\_

History of wearing glasses: ☐ No ☐ Yes \_\_\_\_\_

History of eye surgery: ☐ No ☐ Yes ☐ Left ☐ Right

History of patching: ☐ No ☐ Yes ☐ Left ☐ Right

History of Atropine use: ☐ No ☐ Yes ☐ Left ☐ Right

History prism/foil on glasses: ☐ No ☐ Yes ☐ Left ☐ Right

Other eye problems: ☐ No ☐ Yes \_\_\_\_\_

**Medications:** ☐ No ☐ Yes *If yes, please note medication and dose below:*

\_\_\_\_\_

**Surgeries** (please list all surgeries and estimated dates)

\_\_\_\_\_



**CHILDREN'S EYE**  
SPECIALISTS

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Other pertinent medical history/comments:**

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