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: ___________________________________

TEXT REMINDER STATEMENT: I agree to allow Children's Eye Specialists, LLC to send me automated text messages to the number I have provided for communication purposes. YES____ NO ____

Preferred Phone Number:____

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

CHILDREN'S EYE
SPECIALISTS

Patient Name: ________________________________ DOB:_______________

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

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

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 involvment, the undersigned guarantor agraees 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 deductables, 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 gurantor **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.

____ ___________________
Signature of patient or gurantor **Date**

Patient Name: ________________________________ DOB:_______________

CONSENT FOR TREATMENT

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

[ ] 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	☐	Autism	☐
Previous hospitalization	☐	Recent illness	☐
Developmental delay	☐	Learning disorder	☐
Genetic disorder	☐	Heart disease	☐
Sickle Cell	☐	Asthma	☐
Hydrocephalus	☐	Joint problems/arthritis	☐
Seizures	☐	Psychiatric disorders	☐
Cerebral palsy	☐	Bleeding disorders	☐
Headaches	☐	Diabetes	☐
Downs syndrome	☐	Alcohol use	☐
Thyroid condition	☐	ADD/ADHD	☐

Other Health Conditions: ____

____

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: ____

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	____________

____

CHILDREN'S EYE
SPECIALISTS

Patient Name: ________________________________ **DOB:**_______________

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)*

____

____

Allergies: ____