# Child Information Sheet

Please print

Today's date_____

Childs Name:_____Social Secuity Number_____Race_____

Date of Birth_____Age_____Preferred Language_____Ethnicity_____

Street Address_____Apt #_____ Male Female

City_____State_____Zip_____If student local phone # _____

How would you prefer us to contact you: Call Home Work Cell Text Email

Email:_____ All patient information is kept STRICTLY confidential. Your information is NEVER shared.

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Guarantor:_____Relationship to patient:_____
(Person holding insurance for patient)

Date of Birth _____Social Security Number _____
(Required to bill insurance)

Street address:_____Apt#_____
(unless same as above)

City_____ State_____Zip Code_____

Employer _____Occupation_____

Home Phone_____Work Phone _____Cell Phone _____

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**When glasses come in call:** Home Work Cell Text Email **When contact lenses come in:** Home Work Cell Text Email

Who may we thank for this referral:_____

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## Insurance Information

We willingly accept payment on your behalf from most vision insurance plans. We will file your insurance claim for you whenever possible. We provide these additional services at no additional charge as a courtesy to our patients. If we will be filing an insurance claim for your visit or eyewear today, you must present proof of insurance PRIOR to the initiation of services.

We will always attempt to contact your insurance company to verify your eligibility and your benefit details prior to the initiation of services. Unfortunately, despite our best efforts, insurance companies cannot guarantee benefit information until they receive a bill. It is very important for you to understand that knowledge of your insurance eligibility and benefits is ultimately your responsibility and that you are ultimately responsibility for all charges that you incur.

Name of insurance:_____

Member name:_____Members date of birth __/__/__
(name the insurance is under) (required to bill insurance)

- It is our policy to have a copy of the insurance card so we may bill the insurance effectively.
- You are responsible for applicable co-payments and payment of your medical care within a reasonable time regardless of billing status.
- Services not covered by your insurance are your responsibility.

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## Payment Policies

Payment for professional services is expected in full at the time services are rendered. If ordering glasses or contacts we do require half payment to get them started and the rest when they are picked up.

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**Digital Retinal Exam**

**Would you like to take advantage of our advanced screening technology?** The cost is $39.00 this allows us to see the back of the eye and can detect Retinal problems including: Macular Degeneration, Glaucoma, Retinal holes, Detachments and Systemic Diseases such as Diabetes, Stroke and High blood pressure. These conditions can lead to serious health problems including partial loss of vision or blindness and often develop without warning and progress with no symptoms. Insurance **DOES NOT** cover advanced screening technology.

(You may have this done **OR** we can dilate your eyes)

- **YES** I would like the Digital Retinal Exam (we will probably not need to dilate your eyes.)
- **NO** I do not want the Digital Retinal Exam (Please note the Dr. will need to Dilate your eyes.)

## EYE AND VISION HISTORY

Please check the approximate time since your last **eye examination:**

- 2 years or less
- 3 to 5 years
- 5 years or longer
- Never

Reason for today's visit:

Have you ever worn contact lenses before?

Yes No

Are you interested in wearing contact lenses or updating your contact lens prescription today?

Yes No

Please check the approximate time since your **last general health examination**:

- 2 years or less
- 3 to 5 years
- 5 years or longer
- Never

Please list any medication that you are currently taking, Including Birth control, hormones, and over-the-counter medications/ vitamins:

Please check any of the following vision or eye conditions by which you or any member of your family has ever been affected:

| EYE CONDITION | SELF | FAMILY |
|---|---|---|
| Blindness | | |
| Cataracts | | |
| Glaucoma | | |
| Retinal Disease | | |
| Head/Eye injury and /or surgery | | |
| Lazy eye Or Turned eye | | |
| Other, Please describe: | | |

Please check any of the following vision or eye symptoms which you are currently experiencing:

- Worsening distance vision
- Worsening near vision
- Headache and/or Eye strain
- Double Vision
- Irritation, Watering, and /or Redness
- Floating spots or Flashes of light
- Other, Please describe:

Please check any of the following conditions by which you or any member of you family has ever been affected:

| MEDICAL CONDITION | SELF | FAMILY |
|---|---|---|
| Diabetes | | |
| High Blood Pressure | | |
| Thyroid Disease | | |
| Cancer | | |
| Allergies and/or Asthma | | |
| Migraine Headaches | | |
| Other, Please describe: | | |

Do you smoke? NO YES

Are you allergic to any medications? No Yes (Please list)

Are you interested in learning more about your laser vision correction options today? **Yes No**

**Would you like a copy of our privacy policy? Yes No** Please notify us at any time you have any special needs or restrictions regarding your standard use of your protected health information.

The above information is correct to the best of my knowledge.

Patient/guardian Signature:_____Date:_____