PEDIATRIC PATIENT INFORMATION

Last Name_____ **First Name**_____ **M or F** **Birth Date**____/____/____

Parent/Guardian Information: **HomePh#**_____ **Cell Ph #** _____

Email _____@_____ **Parent SS# (required)** _____

How did you hear about us?_____ **Reason for todays exam**_____

Are you interested in contacts? _____ **Does your child currently wear contacts?** **Y** **N**

Medical Primary Insured's Name : _____ DOB ____/____/____ SS# _____

Vision Primary Insured's Name : _____ DOB ____/____/____ SS# _____

I have read and understood the HIPPA privacy policy provided **Signature** _____

Once a year, the Optomap retinal imaging is recommended to evaluate the full health of your eyes. This provides a fast, easy and permanent record to compare and track your potential eye problems. Without viewing the interior eye, serious eye diseases that can lead to blindness and death will be missed.

Yes **I would like the Doctor to check the full health of my eyes using the Optomap (there is a small fee of $39 for this imaging)**

No I have elected not to have retinal imaging today and will dilate. (Side effects including light sensitivity and blurred vision typically lasting for 6 hours but in some individuals may last for days.)

No I refuse both dilation and retinal imaging. THIS OPTION IS NOT A COMPLETE EXAM
I understand the serious health and vision risks of an incomplete eye exam.

_____ _____
Patient Guardian Signature Date

Non-Covered Services

As our patient, we want to provide you with the best care possible. There may be certain services necessary for the maintenance of good health that may not be covered by your insurance company contract. As we progress with your treatment we will discuss any services we feel may not be covered although we will not always know for certain how your insurance company will process your claim. You will be expected to pay for any non-covered services. Please note that verifying insurance coverage is your responsibility. If you have a question about your coverage, please contact your insurance provider directly. If we file a claim and a service or procedure is denied, you will be billed directly for all costs associated with your visit.

I have read and understand the above information. I accept full financial responsibility for the cost of any uncovered services if provided, and understand payment is due at time of service. I understand that any copayment, coinsurance or deductible I may have is separate from and not included in these fees. I also understand that an additional $30 collections fee will be charged to any account that is turned over to the collections agency after for non-payment of services after 60 days.

_____ _____
Patient Guardian Signature Date

Please review the following and check those that apply. List medications your child takes for each condition.

Medical	Child	Relative-list relationship	List medications
Diabetes			
High Blood Pressure			
Cholesterol			
Heart Disease			
Thyroid			
Cancer (list type)			
Respiratory			
HIV/AIDS			
Allergies to Medication			
Behavioral/Psychiatric			

Growth & Development	Yes	Please Describe
Premature Birth		
Learning Disabilities		
Trouble Reading or Writing		

Ocular	Child	Relative-list relationship	Please list any eye drops used
Glaucoma			
Dry Eye			
Retinal Detachment			
Macular Degeneration			
Eye Surgery			
Eye Injury			
Eye Allergies			
Prior Eye Infections			
Other (list condition)			

Medical Follow Up: _____ **CL F/U:** _____ **Medical / Vision**

Refraction **Non-billable photos** **CL Fitting** **Special Procedure :** _____