Eagleville EYE CLINIC

Child form

Please bring Photo ID & <u>Medical</u> Insurance card to front

Patient Information

Today's Date: _____

Last Name: _____

First Name: _____ MI: ____

Preferred name/nickname: _____

Patient SSN: _____

Gender: M F Date of Birth: _____ Age: ____

Address: _____

City: _____ State: _____ Zip: _____

Do you receive text messages? Yes No

Cell Phone: _____

Preferred number to call: Home Cell Work

Home: _____ Work: _____

Parent Email: _____

May we contact you by e-mail regarding appointments, account information or practice news? Yes No

Parent/Guardian Name: _____

Date of Birth: _____ SSN: _____

School: _____ Grade: _____

Emergency Contact: _____

Phone: _____ Relationship: _____

Privacy Practices for Health Information

The Eagleville Eye Clinic has established a *Privacy Policy* and guidelines *for Privacy Practices* within this office. A copy of these policies can be provided to you at your request.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dr. Rena Cron & the Eagleville Eye Clinic to release any medical or incidental information that may be necessary for medical benefits or to obtain payment for services. This includes but is not limited to vision plans or medical insurances.

Who do you authorize to release to medical information to?
Name: _____ Relationship: _____

CONSENT FOR TREATMENT: I hereby authorize the Eagleville Eye Clinic to administer diagnostic and medical procedures as may be necessary for proper health care.

_____ _____
Patient Signature Date

Patient Medical History

Primary Physician: _____

Location: _____ Phone: _____

Date of Last Physical Exam: _____

Pharmacy: _____

Location: _____ Phone: _____

CURRENT MEDICATIONS (Rx or Over-the-Counter):
(List all medications including eye drops, vitamins, etc.)

_____

Any Allergies to medications: _____

_____

Date of Last Eye Exam: _____

Previous Eye Doctor: _____

Have you had any eye surgeries? ❑ Yes ❑ No

If so, please describe: _____

Premature birth? ❑ Yes ❑ No

Any complications during pregnancy? ❑ Yes ❑ No

If yes above, please describe: _____

Shown normal development? ❑ Yes ❑ No

Had physical/developmental therapy? ❑ Yes ❑ No

Been treated for Lazy Eye? ❑ Yes ❑ No

Additional Testing

To safe-guard the health of your eyes, Dr. Cron may recommend additional diagnostic testing such as digital retinal photographs, extended visual field testing or corneal pachymetry. **These diagnostic procedures are in addition to a routine eye exam and may incur additional charges.**

Payment Agreement/Insurance Authorization

We will gladly file your insurance for today's visit.
****However, we cannot guarantee payment.**

I understand that if insurance is filed for vision or medical services, all payments will be assigned directly to Dr. Rena Cron. **I understand that I am financially responsible for all charges whether or not paid by insurance**, including all collection costs and legal fees for unpaid balances.

_____ _____
Patient Signature Date

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