Welcome To Bayfront Eyecare

1. Today's Date: _____
2. Child's Name: _____
   (Last) (First) (MI)
3. Address: _____
   (Street) (City) (State) (Zip)
4. Phone: _____ Parent's Cell/Work: _____
5. Date of Birth: _____ Age:_____ Male Female
6. Name of Parent/Guardian: _____

   Is anyone else in your household a patient of ours? ☐ Yes ☐ No

   If so, who? _____
7. Special Interest/Hobbies: _____
8. Primary Care Physician: _____ Address/Phone: _____
9. Please rate the child on the following items:

   1- Frequently **2**- Occasionally **3**- Never **4**- Unknown

   ____ Poor reading comprehension
   ____ Learning problems
   ____ Eyes hurt
   ____ Awkward or clumsy
   ____ Uses finger/marker to keep place
   ____ Loses places/skips lines when reading
   ____ Short attention span
   ____ Hyperactive
   ____ Eyes tire
   ____ Poor penmanship
   ____ Rubs eyes

Please Present your medical and vision insurance cards to our receptionist for copying.

Vision Insurance: ☐ VBA ☐ NVA ☐ VSP ☐ BAI ☐ Eyemed ☐ GE
Other: _____

Medical Insurance: ☐ BC/BS ☐ Aetna ☐ UPMC ☐ Health America ☐ Medicare
Other: _____

Policy Holder: Name: _____

Date of Birth: _____ Social Security: _____

Patient's Insurance Authorization/Signature on File

I request that payment of authorized insurance benefits be made either to me or on my behalf to Bayfront Eyecare for any services furnished me/my dependent by that physician/supplier. I authorize any holder of hospital or medical information about me/my dependent to release to the above names insurance company and its agents, any information needed to determine the benefits payable for related services and permit a copy of this authorization to be used in place of the original. I understand that, regardless of my insurance status, I am ultimately responsible for payment of me/my dependent's account.

_____ _____

Insured's Signature **Date**