Welcome To Bayfront Eyecare

1. Today's Date: _____

2. Child's Name: _____
(Last) (First) (MI)

3. Address: _____
(Street) (City) (State) (Zip)

4. Home Phone: _____ Parent's Cell: _____

5. Parent's Work: _____ Parent'sEmail: _____

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**