



Eye Care 4 Kids is a 501(C)3 Charitable Corporation

PATIENT INTAKE FORM (MINOR PATIENT)

PLEASE PROVIDE ALL INFORMATION, INSURANCE, MEDICAL CARDS, VOUCHERS, REFERRALS, ETC., TO THE CLINIC STAFF PRIOR TO EXAM

VISION REFERRAL: ATTACHED

MINOR PATIENT'S NAME _____

CCSD ID # _____ DATE OF BIRTH _____ MALE FEMALE NON-BINARY

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

SCHOOL NAME _____ CURRENT GRADE LEVEL _____ SIBLING IN CCSD? YES NO

RACE (circle *one or more*) American Indian Hispanic/Latino Alaska Native Asian African American Pacific Islander Caucasian Other

PARENT/GUARDIAN NAME _____

CELL PHONE _____ WORK PHONE _____ HOME PHONE _____

EMAIL ADDRESS _____

NUMBER OF PEOPLE IN HOUSEHOLD _____ APPROXIMATE ANNUAL INCOME OF HOUSEHOLD _____

MEDICAID FFS: YES _____ NO _____ MEDICAID NUMBER: _____

OTHER INSURANCE: YES _____ NO _____ INSURANCE NAME _____ POLICY NUMBER: _____

GROUP NUMBER: _____

ADDITIONAL INFORMATION:

ALLERGIES _____

PHYSICIAN _____ PHONE _____

EMERGENCY CONTACT _____ PHONE _____

EXAM INFORMATION:

THIS IS FOR: EXAM EYEGLASSES DATE OF LAST EYE EXAM _____

DOES YOUR CHILD CURRENTLY WEAR EYEGLASSES? YES NO **IF YES, PLEASE BRING THE EYEGLASSES TO THE EXAM*

WHAT CONCERNS DO YOU HAVE WITH YOUR EYES? _____

DUTY TO WARN FOR MINORS: Children are much more physically active than adults, so their eyewear must provide maximum protection. Polycarbonate is a very impact-resistant lens material. It is the material from which bulletproof glass is made. Therefore, EYE CARE 4 KIDS recommend polycarbonate lens material as the lens of choice for all children. EYE CARE 4 KIDS has explained the advantages of polycarbonate lenses to me. If I choose not to have my child wear polycarbonate lenses, I will hold them harmless.

PERMISSION: I give the staff of EYE CARE 4 KIDS permission to treat my/my child's eye, vision or medical problems. I understand that EYE CARE 4 KIDS staff may elect to dilate my/my child's eyes and accept the adverse risks and will hold them harmless. I am ultimately responsible for any and all services rendered on my/my child's behalf. I have read all the information and have answered the above questions. I certify this information is true and correct. I will notify this office of any changes to my/my child's health status or the above information.

I grant Eye Care 4 Kids the right to photograph or video myself and/or my child for use in their promotional material. YES _____ NO _____

PARENT/GUARDIAN SIGNATURE (for minor patient) _____ DATE _____

PLEASE PRINT YOUR NAME _____