INSIGHT EYECARE – MINOR INFORMATION FORM (FOR PTS ↓18)

_____ /_____
First Name MI Last Name Date of Birth

_____/_____
Street City State Zip Social Security #

Phone: (_____)_____ Contact Name_____ Check preferred ☐Text / ☐Call

(_____)_____ Contact Name_____ ☐Text / ☐Call

School_____ Grade_____ Teacher_____

HEALTH HISTORY

Average daily computer/tablet/cell phone use:_____ hours

Date of last eye exam _____ Doctor/Place_____

Has he/she ever worn glasses? ☐Yes ☐No Contact Lenses? ☐Yes ☐No Type:_____

HAS **THE CHILD** EVER BEEN TREATED OR DIAGNOSED WITH ANY OF THE FOLLOWING?

☐ Eye Surgery ☐ Macular Degeneration ☐ Blindness
☐ Glaucoma ☐ Eye Injury ☐ Strabismus/Crossed Eye
☐ Cataracts ☐ Retinal Problems ☐ Amblyopia/Lazy Eye

DOES **THE CHILD** EXPERIENCE ANY OF THE FOLLOWING?

☐ Blurred Vision ☐ Burning ☐ Flashes of Light ☐ Light Sensitivity
☐ Double Vision ☐ Itching ☐ Floaters ☐ Redness
☐ Dry Eye ☐ Tearing ☐ Eye Pain ☐ Unexplained Headache

Date of last routine health appt _____ Name of Regular Physician _____

HAS **THE CHILD** EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?

☐ Currently Ill ☐ Gastrointestinal Problems ☐ Thyroid Problem_____
☐ Cardiovascular Problems ☐ Hepatitis ☐ Sickle Cell/Anemia
☐ Hypertension ☐ Kidney Problems ☐ Blood Clot/Bleeding
☐ Heart Surgery ☐ Arthritis ☐ HIV/AIDS
☐ Heart Attack ☐ Muscle Pain or Disorders ☐ Tuberculosis
☐ Pace Maker ☐ Skin Disorders ☐ Cancer (type/when)_____
☐ High Cholesterol ☐ Stroke/Neurological ☐ Other_____
☐ Ear/Nose/Throat Problems ☐ Anxiety/Depression ☐ Currently Pregnant
☐ Respiratory Problems ☐ Diabetes: Type 1___ Type 2___ How far along?_____

IS THERE A **FAMILY** HISTORY OF THE FOLLOWING? (please indicate relation next to condition: M, F, GM, GF, B, S)

☐ Glaucoma _____ ☐ Retinal Problems _____ ☐ Diabetes _____
☐ Early Cataracts_____ ☐ Macular Degeneration _____ ☐ Cancer _____
☐ Blindness _____ ☐ Crossed Eye/Lazy Eye _____ ☐ Heart Disease _____

DOES THE CHILD USE TOBACCO PRODUCTS, ALCOHOL, OR OTHER SUBSTANCES? ☐Yes ☐No Describe:_____

IS THE CHILD CURRENTLY ENROLLED IN: ☐Auditory/Occupational/Physical Therapy ☐ Resource/Speech/Tutoring

DOES THE CHILD USE ANY EYEDROPS? (include over the counter)_____

PREFERRED PHARMACY _____

LIST ALL MEDICATIONS/SUPPLEMENTS (or provide a medication list to the receptionist):_____

_____

LIST ALL ALLERGIES: (include allergies to MEDICINE or ENVIRONMENTAL SUBSTANCES)

HOW DID YOU HEAR ABOUT US?
☐ Phonebook ☐ Newspaper ☐ Internet ☐ Friend/Family_____ ☐ Other_____

PLEASE CONTINUE ON THE BACK SIDE

Insurance Information: All charges not covered by the insurance carrier will be the responsibility of the patient.

Vision insurance will cover routine services and glasses--benefits only covered once per year (or every 2 years).
Medical insurance MAY cover the examination if there is a medical problem with the eyes.

Vision Insurance: Company_____ Relationship to Insured_____

Policy Holder's Name_____Policy Holder's Date of Birth_____

Policy Holder's Social Security #_____**This is only necessary if you do not have a card

Medical Insurance:

Primary Insurance Company_____ Relationship to Insured_____

Policy Holder's Name_____Policy Holder's Date of Birth_____

Secondary Insurance Company_____ Relationship to Insured_____

Policy Holder's Name_____Policy Holder's Date of Birth_____

I attest that the information included on this form is correct to the best of my knowledge

I understand the HIPAA Privacy Policy as stated below and I understand that a copy of the full privacy practices of InSight Eyecare + Eyewear may be furnished upon request.

Legal Guardian Signature:_____ Date:_____

Summary of HIPAA NOTICE OF PRIVACY PRACTICES

WE MAY USE YOUR INFORMATION FOR TREATMENT PURPOSES BY:

- **Setting up an appointment or confirmation of an appointment already made (including reminder postcards and messages left on an answering machine).**
- **Testing or examining your eyes; Prescribing glasses, contact lenses, or eye medications (and faxing them to be filled) ; showing you vision therapy or low vision aids .**
- **Referring you to another doctor or clinic for eye care, surgery, low vision aids, or vision therapy services or getting copies of your health information from another professional.**

WE MAY USE YOUR INFORMATION FOR PAYMENT PURPOSES BY:

- **Asking about health and vision care plans or other sources of payment.**
- **Preparing and sending bills or claims.**
- **Collecting unpaid amounts (ourselves or through a collection agency or attorney).**

WE MAY USE YOUR INFORMATION TO MAINTAIN THE HEALTH CARE OPERATIONS OF OUR OFFICE BY:

- **Financial or billing audits, Internal quality assurance, Personnel decisions, Participation in managed care plans, Defense of legal matters, Business planning, or Outside storage of records**

***We routinely use your health information inside our office for these purposes without any special permission.**
***If we need to disclose your health information outside our office for these reasons, we will ask you for special written permission.**

USES/DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION:

We are obligated to release your information in the following circumstances:

- **When mandated by state or federal law that certain health information be reported.**
- **Disclosures to governmental authorities regarding victims of suspected abuse, neglect, or domestic violence.**
- **Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.**
- **Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime.**
- **Unless you object, we will also share relevant information about your eye care with your family or friends who are helping you with your eye care.**