## See to Learn History Form

Child's Name: _____ Male___ Female___ DOB:_____

Home Phone: _____ Hispanic/Caucasian/African American/Native American/ Asian/other

Home Address:_____
Street City State Zip

Parent(s) or Guardian(s):_____

How did you learn about our program?____current patient; ____referred by friends/family; _____ radio ads; _____ insurance;_____other _____

Referred by Dr._____

## Eye History

Eye turn___; eyes watering___; eyes red___; white appearance in pupil _____

Explain any eye concerns that you may have: _____

## Medical History

Would you like results shared with child's doctor? ___yes ___no

Child's doctor_____; Phone Number_____

Are immunizations up to date?_____ List allergies to medications:_____

List all medications taken regularly _____ No medications _____

Was pregnancy and delivery normal? _____ List any complications _____

Has your child ever had a high temperature? _____ If yes, how high?_____

List any developmental delays, severe illnesses, accidents, eye, or head injuries, and age they occurred:

_____

Please list any conditions we should know about:

_____

## Family History

Do any family members have: Lazy eye _____ Eye turn _____ Eye tumor _____

Please list any family members with a history of other eye or medical problems List relationship and type of problem:

_____

I acknowledge that this information is accurate to the extent that I can be certain, and will disclose additional information as necessary. This information can only be used in the management of my child's eyes and vision.
I understand the See to Learn vision assessment is without charge. If further services or treatments are recommended, I may choose any eye care professional to provide those services.

_____ Date: ____/____/_____
Parent or Guardian Signature

# Clarity Eye Care

## Patient Financial Information Sheet

I understand that payment in full is due at time of service unless other arrangements have been made.

Name of Patient_____DOB_____

Name of Insured_____DOB_____

Relationship to patient_____ SS# of insured_____

Address if different_____ Phone_____

Employer of insured_____ Occupation_____

Name of Vision Insurance_____

ID#_____ Group/Policy #_____

Name of Medical Insurance_____

ID#_____ Group/Policy #_____

**Authorization and Release:**

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to me or my dependent to:_____

_____ _____

Signature of patient or parent if minor Date

## HIPAA PRIVACY PRACTICE ACKNOWLEDGEMENT

**I am aware of Clarity Eye Care's Notice of Privacy Practices.**

_____I would like a copy. _____I do not want a copy.

**Signature:** _____ **Date:** _____