New England Eye/Renaissance School Vision Center: Patient Information

Patient Name: ____ **Sex (circle one):** M / F
(First) (Last) (MI)

Address: ____

Telephone: _________________________

Patient Date of Birth (mm/dd/yyyy): _____/___/_____ **Parent/Guardian Name:** _____________________

Primary Insurance: **Plan Name** __________________________________ **Policy #** _______________________

Subscriber of Insurance ___________________ **Subscriber DOB**____________

Secondary Insurance: **Plan Name** _________________________________ **Policy #** ______________________

Subscriber of Insurance ___________________ **Subscriber DOB**____________

Primary Care Physician Information

Name: ____

Address/Practice: ___________________________________ **Phone:** _________________________

AUTHORIZATION MUST BE SIGNED FOR INSURANCE/BILLING
I hereby authorize the New England Eye Institute/Boston Renaissance Public Charter School to release any information necessary for billing purposes or any medical information that is needed for any utilization review or quality assurance activities. I assign all medical benefits to which I am entitled to New England Eye Institute. I agree that I am responsible for any co-payments or deductibles as stated in any Explanation of Benefits. I hereby agree that I am responsible for any services not covered by my insurance at the time services are rendered and agree to provide referrals as required by my insurance company. To the best of my knowledge all of the above information is true and accurate.

Parent/Guardian Signature: **Date:**

PARENTAL CONSENT
We are requesting your permission to perform a comprehensive eye examination on your son/daughter. A full pediatric eye exam will last about an hour. These tests are standard eye care procedures routinely used with children in a doctor's office for an eye examination. As part of a comprehensive eye examination, eye drops are used that will temporarily numb the front of the eye, making the pupils large and preventing the ability to focus on near objects. There may be some mild stinging for a few seconds when the drops are instilled. The pupils will remain large for approximately 6 hours. These drops are routinely used in eye exams of babies and children. Disposable sun protection will be provided to reduce possible discomfort from sunlight.

I __________________________________ hereby authorize New England Eye Institute/Boston Renaissance Charter Public School to examine my son/daughter ____________________________. I understand that giving my authorization will allow a complete eye exam to be conducted, including dilation of his/her eyes by putting drops in them.

Parent/Guardian Signature: **Date:**

I hereby authorize New England Eye Institute/Boston Renaissance Charter Public School to share results of my child's eye exam with his/her teachers. Yes_____ No_____

(10/10/2010)