Holloway Vision Care **MOBILE VISION CLINIC** Patient Information Form

Comprehensive Eye Exams ∽ *Rx Glasses* ∽ *Vision Screenings*

No Out-of-Pocket Cost ∽ Exams and Glasses Dispensing Provided on Site at School ∽ Vision Reports Sent Home
Valid insurance necessary to receive full range of services including glasses

☐PLEASE CHECK HERE if you do NOT want your child to be seen by our doctors. Please be aware that your child is eligible for services from our clinic even if they have had an exam elsewhere within the last year. If your child is receiving annual eye care from a practitioner you are satisfied with, we encourage you to continue care with that practitioner. If you are refusing services, please still fill out the Contact Information box; the rest of the form may be left blank. Thank you!

Contact Information

Student's Name:______________________________ Gender M F DOB ___/___/____ Age______
(As it appears on insurance card)

Mailing Address:______________________________ Phone number:______________

Grade:__________ School:______________________________

Parent/Guardian name: ______________________________ Relation to patient:______________

Names of all other parents/guardians/family members you authorize to have access to these medical records: ______________
____

Insurance Information (please check one) ☐Medicaid ☐VSP ☐Optilegra ☐Other:______________

Insurance Policy Number: ______________________________

Name of Insured (if parent/guardian/family member):______________________________ Insured's DOB:______________

For VSP only please provide the last 4 digits of the insured's SS#: ______________

Do you have any specific concerns regarding your child's eyes and/or vision? Please describe: ______________

Eye Exam and Glasses History

Last Eye Exam: ☐Less than 1 year ☐1 year ☐2 years ☐More than 2 years ☐Never had one

Please check one: ☐Currently wears glasses ☐Wore glasses in the past ☐Never wore glasses

Personal Health History (Please List, or check "None")

Any Past Eye Injuries, Eye Surgeries, or Eye Conditions?:______________ ☐None

Any Current Health Conditions?:______________ ☐None

Any Past Surgeries or Hospitalizations?:______________ ☐None

Taking any Medications?:______________ ☐None

Any known Drug Allergies?:______________ ☐None

Any Special Needs? (ie. wheelchair, developmental disability, etc.)______________

Primary Care Doctor:______________ ☐Check Here if Patient is Pregnant

Family Health History

Family Member Eye History: ☐Glaucoma ☐Macular Degeneration ☐Diabetic Eye Disease ☐Retinal Detachment ☐Other:

Family Member Medical History: ☐Heart Disease ☐Diabetes ☐Autoimmune Disease ☐Cancer ☐Other:

Notice of Privacy Practices

I acknowledge that I have been offered, and taken by my choosing, a copy of Holloway Vision Care's Notice of Privacy Practices. This form details your rights as a patient and states how we take steps to protect your private health information, including not sharing patient information unless we have obtained your written consent. The form is available for review at the school office and a copy may be mailed to you at your request.

⇨Signature: ______________________________

Consent for Eye Examination

I, ______________________________, as a legally responsible guardian of ______________________________,
(print parent/legal guardian name) (print child's name)

give my consent for comprehensive eye examination services performed by a licensed optometrist.

I authorize *Holloway Vision Care LLC* to bill the insurance provider listed above for professional services and prescription glasses.

⇨Parent/Legal Guardian Signature ______________________________ Date ______________