Patient Information and Authorization to Treat a Minor

PATIENT INFORMATION

Name: _____ (First / Last / Middle) **Birthdate:** _____ (Mo/Day/Yr)

Address: _____ **Gender:** _____

City: _____ **State:** _____ **Zip:** _____ **E-mail:** _____

Primary phone: _____ **Cell phone:** _____ **Social Security #:** _____

Marital Status: _____ **Employer:** _____ Do you live in an assisted living facility? ☐YES ☐NO

Preferred Language: _____ **Ethnicity:** _____

Emergency Contact: _____ **Phone:** _____

Primary Care Doctor: _____ **Office:** _____

Preferred Pharmacy: _____ **Location:** _____

Whom may we thank for referring you? _____ **Office:** _____

RESPONSIBLE PARTY INFORMATION (If patient is under 19 years of age, a responsible party must be indicated)

☐ SELF

☐ OTHER _____ (First / Last / Middle)

Relationship to patient: _____ **Address:** _____

Phone: _____ **Work Phone:** _____ **Date of Birth:** _____

Employer: _____ **E-mail:** _____

INSURANCE INFORMATION

☐**SELF** **Name of Policy holder:** _____ **Birthdate:** _____

Policy Holder last 4 of SSN: _____ **Phone:** _____ **Relationship to patient:** _____

Insurance Company: _____ **Insurance ID:** _____

Vision Insurance (such as VSP or EyeMed) **:** ☐**VSP** ☐**EYEMED** ☐**NONE** **ID#**(if provided): _____

AUTHORIZATION TO TREAT MINOR

By signing this, I authorize Kearney and Grand Island Eye Institute to examine & treat my minor (under 19 years of age) child in my absence. Please list below those that may bring my minor child to their visit.

Name(1):	**Name(2):**
Phone:	**Phone:**
Relationship to Patient:	**Relationship to Patient:**

By signing this form, I hereby authorize Kearney Eye and Grand Island Eye Institute to release my health information for purposes of treatment, payment and healthcare operations as described in their Notice of Provider Privacy Practices. By signing this form, I am also indicating the above information is complete and correct to the best of my knowledge. I understand that it is my responsibility to inform my doctor's office if I, or my minor child, have a change in information.

Name: _____ Signature: _____ Date: _____

Print name(or Patient/Guardian/Guarantor)