ALEXANDER VISION EYE CENTER EYE CLINIC APPLICATION

PATIENT'S NAME_____BIRTHDATE_____

Ethnicity _____ SEX _____

FATHER'S NAME_____BIRTHDATE _____

MOTHER'S NAME_____BIRTHDATE_____

ADDRESS_____CITY_____ZIP _____

HOME PHONE # _____ IF NONE, LIST NEIGHBOR or RELATIVE'S PHONE #_____

DEPENDENTS: (DO NOT INCLUDE THOSE LISTED ABOVE)

NAME_____AGE_____ SEX____ NAME_____ AGE_____SEX_____

NAME_____AGE_____ SEX____ NAME_____ AGE_____SEX_____

NAME_____AGE_____ SEX____ NAME_____ AGE_____SEX_____

INCOME: (LIST ***ALL*** MONTHLY INCOME BEFORE TAXES)

FATHER'S EMPLOYER _____PHONE #_____***MONTHLY*** SALARY _____

MOTHER'S EMPLOYER _____PHONE #_____***MONTHLY*** SALARY_____

SOCIAL SECURITY/DISABILITY/SSI _____ A.F.D.C._____CHILD SUPPORT_____

UNEMPLOYMENT COMPENSATION _____ WORKMAN'S COMPENSATION_____

OTHER (NAME SOURCE AND AMOUNT)_____

WHAT IS YOUR CHILD'S VISION PROBLEM?_____

HAS YOUR CHILD BEEN A PATIENT AT THE EYE CLINIC BEFORE?_____IF SO, WHEN? _____

HAS YOUR CHILD HAD EYE CARE AT ANY LOCATION?_____IF SO, WHERE? _____

WHO IS YOUR CHILD'S DOCTOR?_____NAME OF ANY DOCTOR VISITED RECENTLY_____

IS ABOVE PATIENT COVERED BY MEDICAID?_____BY INSURANCE?_____COMPANY_____

WHO REFERRED YOU TO THE CLINIC? NAME:_____TITLE_____

SCHOOL OR OTHER AGENCY _____

THIS PERSON'S EMAIL _____

REFERRAL PHONE#_____CHILD'S ACUITY AT SCREENING_____RIGHT_____LEFT

OTHER CONCERNS: _____

FOR CLINIC USE ONLY

DATE RECEIVED:_____
SCREENED BY:_____
APPROVED:_____DENIED:_____

SIGNATURE OF PARENT/GUARDIAN and NURSE

_____

_____

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