Chicot Health Clinic - Eye Center
11102 Chicot Road
Little Rock, AR 72103
501-447-7070

Today's Date: ____/____/____ School and Grade Level: _____

Patient Name: _____

Home Address: _____

Preferred Phone: _____ Alternate Phone: _____

Birth Date: ___/___/_____ Age: ____ Male / Female SSN:_____

Parent/Guardian Name: _____

Please list whom we may notify in the event of an emergency:

Contact: _____ Relationship: _____ Phone:_____

HISTORY:

Last eye exam:_____Last eye clinic _____

Does the patient wear glasses? Y/N Previous eye problems:_____

Does the patient wear contact lenses? Y/N Brand:_____ Power:_____

Cancer Diabetes Heart Disease Headaches/Migraines Developmental Delay

Allergies Behavior/Emotional Problems ADD/ADHD Eczema Seizure Disorder

Other Health or Eye Problems:_____

* List all medications taken or eye drops used (prescription and over-the-counter):

_____

_____

Preferred Pharmacy:_____

FAMILY HISTORY:

Glaucoma Amblyopia Retinal Detachment Diabetes Cancer Heart Disease Asthma

High Cholesterol Allergies Mental Health Issues Seizure Disorder Substance Abuse

Additional Family History:_____

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Insurance Information

Medical Insurance : _____

Insurance ID Number _____ Group Number: _____

Policy Holder Name: _____Date of Birth:_____

SS#_____ Relationship to insured: Self Child Other: _____

Vision Insurance: _____

Insurance ID Number _____ Group Number: _____

Policy Holder Name: _____Date of Birth:_____

SS#_____ Relationship to insured: Self Child Other: _____

Employer: _____

Please provide a copy of all insurance cards front and back as well as photo id

Complete this section if patient is a minor

Responsible Party: _____Relation to Patient:_____

Birth Date: ___/___/_____ Male / Female SSN: _____ Age: _____

Marital Status: Single Married Widowed Divorced

Spouse's Name:_____

Mailing Address (if different from patient):

_____

Employer: _____

Work Phone: _____

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Please read the following statements

All operations of the Chicot SBHC and their providers will be in full compliance with the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA).

- I understand my insurance will be billed for service provided by the SBHC and I authorize the provider to use my signature all on insurance submissions.
- I understand and authorize the sharing of information between the SBHC, my child's primary care physician and the Little Rock School District, as needed.
- I understand there will be an opportunity to read the HIPAA Privacy Practices for Protected Health Information.
- I give consent for my child's eyes to be dilated if necessary. Dilation, fluorescein (cornea), and possibly other eye drops may be necessary to perform a thorough comprehensive eye exam.
- If the child has a glasses benefit through ARkids, Medicaid, or lack of insurance, I give consent for the staff at the Chicot Health Clinic Eye Center to select my child's glasses if I am not present.
- I will hold neither the Chicot Health Clinic, its volunteers, nor any of their affiliates liable for any errors of omission, misdiagnosis, or injury. Professional medical staff, doctors, nurses, and others working for the Chicot Health Clinic may be volunteers. As volunteers they are immune from civil suit/litigation in regards to their services to you/your child as a patient.
- I understand that this form expires 1 year from the date signed.

Patient Name _____

Responsible Party Printed Name _____

Responsible Party Signature _____

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Date: ____/ ____/_____