315 Hospital Drive, Barbourville, KY 40906 | Phone: (606) 546-4166 | Fax: (606) 546-4167
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MINOR PATIENT REGISTRATION & CONSENT FORM

To be completed by a parent or legal guardian for patients under 18 years of age.

MINOR PATIENT INFORMATION

PATIENT'S LAST NAME | FIRST NAME | MIDDLE INITIAL

PREFERRED NAME / NICKNAME | DATE OF BIRTH (MM/DD/YYYY) | SOCIAL SECURITY NUMBER

STREET ADDRESS | APT/SUITE

CITY | STATE | ZIP CODE | COUNTY

SEX

☐ Male ☐ Female

DOES THE CHILD WEAR GLASSES?

☐ Yes ☐ No

LENSES?

☐ Yes ☐ No

SCHOOL NAME | GRADE | DATE OF LAST EYE EXAM

PARENT / LEGAL GUARDIAN INFORMATION

PARENT / GUARDIAN #1 FULL NAME | RELATIONSHIP

HOME PHONE | CELL PHONE | WORK PHONE

EMAIL ADDRESS | EMPLOYER

PARENT / GUARDIAN #2 FULL NAME | RELATIONSHIP

HOME PHONE | CELL PHONE | WORK PHONE

EMERGENCY CONTACTS

EMERGENCY CONTACT #1 NAME | RELATIONSHIP | PHONE

EMERGENCY CONTACT #2 NAME | RELATIONSHIP | PHONE

INSURANCE INFORMATION

INSURANCE COMPANY NAME

PHONE NUMBER ON CARD

SUBSCRIBER / POLICY HOLDER NAME

RELATIONSHIP TO PATIENT

SUBSCRIBER DOB

MEMBER / ID NUMBER

GROUP NUMBER

MEDICAL & OCULAR HISTORY

CURRENT MEDICATIONS (LIST ALL)

MEDICATION ALLERGIES

REASON FOR TODAY'S VISIT

CHECK ANY CONDITIONS THAT APPLY TO THE CHILD

- ☐ Diabetes
- ☐ Asthma
- ☐ Seizures / Epilepsy
- ☐ ADD / ADHD
- ☐ Autism
- ☐ Developmental Delay
- ☐ Hearing
- ☐ Learning
- ☐ Premature
- ☐ Other:

CHECK ANY **EYE** CONDITIONS THAT APPLY TO THE CHILD OR FAMILY

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Lazy Eye / Amblyopia
- ☐ Crossed Eyes / Strabismus
- ☐ Color Blindness
- ☐ Retinal Problems
- ☐ Eye Injury/ Surgery

FAMILY HISTORY OF EYE DISEASE (SPECIFY CONDITION AND RELATION)

AUTHORIZED ACCOMPANYING ADULT (IF PARENT/GUARDIAN IS NOT PRESENT)

NAME

RELATIONSHIP

PHONE

CONSENT FOR TREATMENT OF MINOR

I, the undersigned, being the parent or legal guardian of the minor named on this form, hereby authorize the physicians and staff of **Access Health Vision** to perform eye examinations, diagnostic testing, and any medically appropriate procedures or treatments as deemed necessary by the treating eye care provider. This includes dilation, OCT imaging, contact lens fitting, and administration of topical medications. I authorize Access Health Vision to release my child's medical records to insurance companies for claims processing and to referring physicians involved in my child's care. I understand that I am financially responsible for all charges including copayments, deductibles, and non-covered services. If someone other than a parent or legal guardian brings the minor to an appointment, this signed consent must be on file **before** any examination or treatment will be provided.

PARENT / LEGAL GUARDIAN AGREEMENT

By signing below, I certify that I am the parent or legal guardian of the minor named on this form and that I have the legal authority to consent to medical treatment on their behalf.

PARENT / LEGAL GUARDIAN NAME (PRINTED)

DATE OF BIRTH (GUARDIAN)

PARENT / LEGAL GUARDIAN SIGNATURE

DATE

RELATIONSHIP TO PATIENT

WITNESS INITIALS