Child Patient Demographics

_____**Male** **Female**_____ **Date:**_____

_____White _____African/*American* _____ *Asian* _____ *Other* ____Non-Hispanic ____ Hispanic/Latino

---

PATIENT FULL NAME_____Preferred Name_____

Birthdate: _____ **Social Security #**_____

Address_____City/St_____Zip_____

Home_____ Work_____ Cell_____Text _____YES ____ NO

FATHER FULL NAME_____Preferred Name_____

Birthdate: _____ Social Security #_____

Address IF DIFFERENT_____

City_____State _____Zip_____

Home_____ Work_____ Cell_____Text _____YES ____ NO

EMPLOYER: _____ OCCUPATION_____

MOTHER FULL NAME_____Preferred Name_____

Birthdate: _____ Social Security #_____

Address IF DIFFERENT_____

City_____State _____Zip_____

Home_____ Work_____ Cell_____Text _____YES ____ NO

EMPLOYER: _____ OCCUPATION_____

PRIMARY INSURANCE COMPANY: VSP VCP EyeMed BlueCross Blue Care United Health March Vision
CoverKids TNSelect Other:_____

RESPONSIBLE PARTY INFORMATION (circle one): Father Mother Step-Parent Fed/State Government

STEP-PARENT FULL NAME IF NOT LISTED ABOVE _____

Birthdate: _____ Social Security #_____

Address IF DIFFERENT_____

City_____State _____Zip_____

Home_____ Work_____ Cell_____Text _____YES ____ NO

EMPLOYER: _____ OCCUPATION_____

Child Patient Demographics

Referred By (Circle One): Relative Friend Phone Book Website Insurance Doctor

Name of Person who referred you:_____

I hereby authorize the disclosure of my personal health information to my referring physician, primary care physician, and insurance company, if applicable, via the use of written or fax transmittal, to carry out treatment, payment or health care operations.
I accept full financial responsibility for services rendered by Spring Creek Eye Center and agree to pay all reasonable collection cost and attorney fees in the event of default of payment on my charges. I further authorize and request insurance payments be made directly to Spring Creek Eye Center should they elect to receive such payment. My signature below indicates that I have read and fully understand.

Signature: _____ Date:_____

ACKNOWLEDGEMENT OF PRIVACY POLICY AND PRACTICES

I understand that in an attempt to protect the privacy of my identifiable health information, **Spring Creek Eye Center** has established a *Privacy Policy* and guidelines for *Privacy Practices* within their office. This information details the use and/or disclosure of information contained in my personal medical/optometric records kept for the purposes of diagnosis, treatment, payment and health care operations. In accordance with **HIPAA** Regulations, a copy of the **Spring Creek Eye Center** *Privacy Policy & Practices* has been made available to me while in the office today. Should I choose to have a personal copy; one will be given to me at no charge.

{ } I have read, understand and acknowledge the *Privacy Policy & Practices* of **Spring Creek Eye Center.**
{ } I have elected not to read the *Privacy Policy & Practices* of **Spring Creek Eye Center.**
{ } A copy of the **Spring Creek Eye Center** *Policy & Practices* was given to me today.

Signature: _____ Date:_____

Privacy Options – In some cases, it is not possible to reach our patients during work hours to discuss test results, future appointments and account balances. Your response to the questions below will give us guidance when we cannot contact you personally.

May we leave a message, either on the answering machine or with the person answering the home phone,

regarding appointments? ____Yes _____No

With whom may we speak to regarding the insurance, billing questions or financial arrangements?

To whom may we speak? _____

With whom may we speak to regarding test results or other medical information?

To whom may we speak? _____

Pharmacy Information

Pharmacy Name: _____ Phone # _____

Pharmacy Address: _____