Welcome To Bayfront Eyecare

3. Address: (Street) (City) (State) (4. Phone: Parent's Cell/Work: 5. Date of Birth: Age: Male Female 6. Name of Parent/Guardian: Is anyone else in your household a patient of ours? Yes No If so, who? 7. Special Interest/Hobbies: 8. Primary Care Physician: Peor reading comprehension Peor reading comprehension Learning problems Learning problems Hyperactive Eyes tire Awkward or clumsy Poor penmanship Uses finger/marker to keep place Loses places/skips lines when reading Please Present your medical and vision insurance cards to our receptionist for copying. Vision Insurance: VBA NVA VSP BAI Eyemed GE Other: Medical Insurance: BC/BS Aetna UPMC Health America Medicare Other: Policy Holder: Name: Date of Birth: Social Security: Patient's Insurance Authorization/Signature on File I request that payment of authorized insurance benefits be made either to me or on my behalf to Bayfront Eye for any services Furnished me/my dependent by that physician/supplier. I authorize any holder of hospital or n information about me/my dependent to release to the above names insurance company and its agents, any information needed to determine the benefits payable for related services and permit a copy of this authorizatio be used in place of the original. I understand that, regardless of my insurance status, I am ultimately responsible used in place of the original. I understand that, regardless of my insurance status, I am ultimately responsible used in place of the original. I understand that, regardless of my insurance status, I am ultimately responsible used in place of the original. I understand that, regardless of my insurance status, I am ultimately responsible used in place of the original. I understand that, regardless of my insurance status, I am ultimately responsible used in place of the original. I understand that, regardless of my insurance status, I am ultimately responsible used in place of the original. I understand that, regardless of my insurance status, I am ultimately r	1.	Today's Date:	_								
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6. Name of Parent/Guardian: Is anyone else in your household a patient of ours? Yes No If so, who? 7. Special Interest/Hobbies: 8. Primary Care Physician: 9. Please rate the child on the following items: 1- Frequently 2- Occasionally 3- Never 4- Unknown Poor reading comprehension Short attention span Learning problems Hyperactive Eyes tire Awkward or clumsy Uses finger/marker to keep place Loses places/skips lines when reading Please Present your medical and vision insurance cards to our receptionist for copying. Vision Insurance: VBA NVA VSP BAI Eyemed GE Other: Medical Insurance: BC/BS Aetna UPMC Health America Medicare Other: Policy Holder: Name: Date of Birth: Social Security: Patient's Insurance Authorization/Signature on File I request that payment of authorized insurance benefits be made either to me or on my behalf to Bayfront Eye for any services furnished me/my dependent by that physician/supplier. I authorize any holder of hospital or n information about me/my dependent by that physician/supplier. I authorize any holder of hospital or n information needed to determine the benefits payable for related services and permit a copy of this authorizatie be used in place of the original. I understand that, regardless of my insurance status, I am ultimately responsite used in place of the original. I understand that, regardless of my insurance status, I am ultimately responsite used in place of the original. I understand that, regardless of my insurance status, I am ultimately responsite used in place of the original. I understand that, regardless of my insurance status, I am ultimately responsite used in place of the original. I understand that, regardless of my insurance status, I am ultimately responsite the services and permit a copy of this authorization and the payable for related services and permit a copy of this authorization and the payable for related services and permit a copy of this authorization and the payable for related services and permit a copy of this authoriza	4.	Pnone:				Parent's Cell/Work:					
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