

EYE EXAMS and GLASSES for your child at Sierra Grande School District R-30

Adventure Vision, a Colorado based children's vision practice, will be hosting an eye exam event with Sierra Grande School District R-30. This is an opportunity for children of the district to receive an onsite, comprehensive eye exam, by a licensed Optometrist.

After the exam, if glasses are needed, Adventure Vision will have a large selection of children's frames to choose from!

Event Information:

What: Eye Exams for Sierra Grande School District Students (Medicaid or Uninsured)

Where: Sierra Grande School

- 17523 E Highway 160, Blanca, CO 81123

When: November 28-29, 2023

In order for your child to receive an eye exam, the school site must receive the following forms completed with the requested information in order to add your child to the schedule. Appointment availability is limited, and students will be accepted in the order forms are received.

- ☐ Consent form (sign below)
- ☐ Patient Information Form (2 pages)
- ☐ Patient Medical History (1 page)

Student Information

Name: _____

Gender: ☐ M ☐ F

Date of Birth: _____ Age: _____ Grade: _____ Phone# _____

When did your child last visit the eye doctor? ☐ In the past 6 months ☐ In the past year ☐ More than a year ☐ Never

What is the name of the eye doctor? _____ Does your child wear glasses? ☐ YES ☐ NO

Parent Consent

As the parent/legal guardian of the child listed above, I give consent for the following: (Check Yes or No for each)

- For my child to have a full eye exam with Adventure Vision: ☐ YES ☐ NO
- For a representative of the school district to be present for the appointment if needed ☐ YES ☐ NO
 - (i.e., help pick out glasses, sign off on glasses when dispensed)
- For Adventure Vision to process insurance claims on my behalf for services/materials: ☐ YES ☐ NO
 - Medicaid covers an annual eye exam and glasses. There is no out of pocket expense.
 - If a child is uninsured Adventure Vision will partner with Von's Vision for a voucher to cover all costs of services
- For my child to receive dilation drops only if needed. ☐ YES ☐ NO
 - In some cases, dilation might be needed in order to complete full exam. Dilation drops are to enlarge the pupil allowing the doctor to see inside the eye. These drops will not harm the eye. The child might experience blurry vision and light sensitivity if dilation drops are given. The pupil will appear larger than normal but will return to normal size within a few hours.
- For a release of photo consent taken on site for use of Social Media to promote the event. ☐ YES ☐ NO

Parent/Guardian Signature _____ Date _____

Parent/Guardian Name (printed) _____

General Dentistry and Vision for Children and Young Adults!

7405 E. Iliff Ave., Denver, CO 80231 | (P) (303) 752-6692 | (F) (888) 389-2487

We are happy to welcome you to our office!
Please completely fill out this form and if you have any questions, we will be glad to help you!

Patient Information

Date _____
Patient's last name _____ First name _____ Middle initial _____
Prefers to be called _____ Date of Birth _____ Sex ☐ Male ☐ Female
Social Security# _____ School _____
Email address(es) _____
Home address _____ City, State, Zip code _____
Home phone () _____ Cell phone () _____

Parent / Guardian (if patient is under 18)

Custodial parent(s) name(s) _____
Patient lives with (check all that apply) ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent(s)
☐ Other _____
Primary Guardian Full Name _____ Date of Birth _____
Occupation _____ Email address _____
Address (if different) _____
Home Ph. () _____ Cell Ph. () _____ Work Ph. () _____
Secondary Guardian Full Name _____ Date of Birth _____
Occupation _____ Email address _____
Address (if different) _____
Home Ph. () _____ Cell Ph. () _____ Work Ph. () _____

Financial Responsibility

Who is financially responsible for this account? _____
Address _____
City _____ State _____ Zip code _____
Home phone () _____ Cell phone () _____
Email address(es) _____
Social Security # _____ Employer _____
Who will be responsible for bringing the patient to appointments? _____

Dental / Orthodontic Insurance

Primary policy holder's full name _____
Social Security # _____ Relationship to patient _____
Address and phone number (home or work) _____
Employer _____ Address _____
Insurance company _____ ID# _____
Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know
Secondary policy holder's full name _____ Date of Birth _____
Social Security # _____ Relationship to patient _____
Address and phone number (home or work) _____
Employer _____ Address _____
Insurance company _____ Group # _____
Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Primary policy holder's full name _____ Date of Birth _____
 Social Security # _____ Relationship to patient _____
 Address and phone (if not listed on front.) _____
 Employer _____ Address _____
 Insurance company _____ Policy # _____ ID# _____

Secondary policy holder's full name _____ Date of Birth _____
 Social Security # _____ Relationship to patient _____
 Address and phone (if not listed on front.) _____
 Employer _____ Address _____
 Insurance company _____ Policy # _____ ID# _____

Patient Physician _____ City, State _____
 Last seen _____ Reason _____ Appointment _____
 Most recent physical exam _____
 Other physicians/health care providers have been referred to _____
 Name _____
 Reason _____
 Name _____ City, State _____
 Reason _____

Acknowledgment of Receipt of Notice of Privacy Practices Posted. Copies available upon request.

I have read over this office's Notice of Privacy Practices records and materials.

X _____
 Patient/Guardian Signature _____ Date _____

----- For Office Use Only -----

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

() Individual refused to sign () Communication barriers prohibited obtaining acknowledgment.

() An emergency situation prevented us from obtaining acknowledgment. () Other (Specify) _____

I authorize the Provider to release any information including the diagnosis and records of treatment or examination rendered to the patient during the period of such are to third party payers and/or other health practitioners. I authorize and request my insurance company to assign benefits and pay directly to the Provider or Provider's group those insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I authorized the use of my signature on all insurance submissions. I agree to be responsible for payment of all services rendered on my behalf or my dependents

X _____
 Patient/Guardian Printed Name _____
 X _____
 Patient/Guardian Signature _____ Date _____

Medical History (If you are filling this page out for your child, provide information pertaining to them.)

Although we primarily treat the area in and around the eye, one's eye is a part of the entire body. Previous health problems and/or medications could have an important interrelationship with your eye's health. Please answer each of the following questions as completely as possible. **Thank You!**

Patient Name _____ Patient Date of Birth _____

- Has your child ever been hospitalized for any reason? No () Yes () If yes please explain _____
- Has your child ever had a serious head or neck injury? No () Yes () If yes please explain _____
- Is the patient currently pregnant or nursing? No () Yes () If yes please explain _____

- Does your child have, or ever had, any of the following?

() AIDS/HIV Positive	() Developmental Disability	() Frequent Headaches	() Hypoglycemia	() Prostate Disease
() Alzheimer's Disease	() Depression	() Gout	() Hyperthyroid	() Psychiatric Care
() Anaphylaxis	() Diabetes	() Hay Fever	() Hypothyroid	() Recent Weight Loss
() Arthritis	() Dry Mouth	() Hearing Loss	() Kidney Disease	() Rosacea
() Asthma	() Emphysema	() Heart Attack/Failure	() Learning Disability	() Shingles
() Blood/Bleeding Disorder	() Epilepsy or Seizures	() Heart Trouble/Disease	() Leukemia	() Sinus Trouble
() Breathing Problems	() Excessive Thirst	() Hepatitis A, B, or C	() Liver Disease	() Stomach Disease
() Cancer	() Fainting Spells/Dizziness	() Herpes	() Low Blood Pressure	() Stroke
() Cerebral Palsy	() Frequent Cough	() High Cholesterol	() Lung Disease	() Tuberculosis
() Chicken Pox	() Frequent Diarrhea	() High Blood Pressure	() Multiple Sclerosis	() Tumors or Growths
() Cold Sores/Fever Blisters	() Fatigue Syndrome	() Hives Rash	() Osteoarthritis	() Ulcers

Allergies

- Is your child allergic to any of the following?

() Aspirin () Penicillin () Amoxicillin () Sulfa () Codeine () Local Anesthetic () Pollen () Pet Dander () Latex

Please list any other allergies not listed above:

Medications

- Is your child taking any medications, pills, or drugs? Yes () No () Please list current medications, including non-prescription:

Ocular History

- Has your child had any eye surgeries? No () Yes () If yes please explain _____
- Does your child currently wear glasses? No () Yes () If yes please explain _____
- Does your child currently wear contact lenses? No () Yes () If yes please explain _____
- When was your child's last eye exam? _____ Where: _____
- Does your child have, or ever had, any of the following

() Crossed Eye/ Lazy Eye () Corneal Disease () Injury/Trauma () Retinal Disease () Retinal Detachment () Cataracts () Glaucoma
() Macular Degeneration () Diabetic Retinopathy () Red eye () Dry/Burning Eyes () Retinitis Pigmentosa () Itchy Eye () Iritis

Please list any other eye problems not listed above:

Family History

- Does anyone in your family (blood relative) have, or ever had, any of the following?

* (Note relation to patient: M- Mother, F- Father, U- Uncle, A- Aunt, S- Sister, B- Brother, GF- Grandfather, GM- Grandmother)

() Glaucoma _____	() Cataracts _____	() Cornea Disease _____
() Macular Degeneration _____	() Diabetic Retinopathy _____	() Retinal Detachment _____
() Retinitis Pigmentosa _____	() Crossed/Lazy Eye _____	() Diabetes _____
() Heart Conditions _____	() High Blood Pressure _____	

Please list any other family health or eye problems:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or my child's) health. It is my responsibility to inform the vision office of any changes in my (or my child's) medical status. I also authorize the vision staff to perform the necessary vision services I (or my child) may need.

Signature of Patient (or parent/guardian if minor)

Date

Optometrist Review

Date