



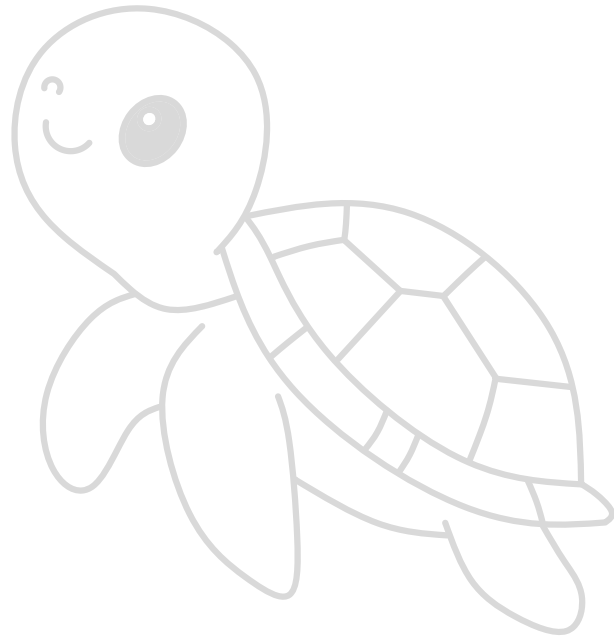
# MELBOURNE EYE

278 N. Wickham Rd.  
Melbourne, FL 32935

Phone : 321-253-9228

Fax : 321-253-9446

*Welcome,*



Thank you for choosing Melbourne Eye,  
we look forward to working with you and  
your children for all their eye care needs.

Attached is their new patient paperwork.  
Please fill out to the best of your ability.

# Patient Information :

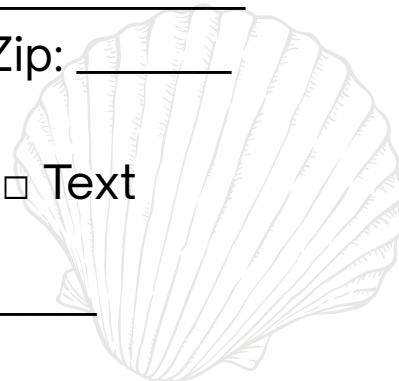
Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_  Call  Text

Email: \_\_\_\_\_



## Insurance Information :

Vision Insurance:  VSP  EyeMed  Spectera  None

Medical Insurance (Primary):      Medical Insurance (Secondary):

Company: \_\_\_\_\_

Company: \_\_\_\_\_

Member ID: \_\_\_\_\_

Member ID: \_\_\_\_\_

Primary Care Physician :

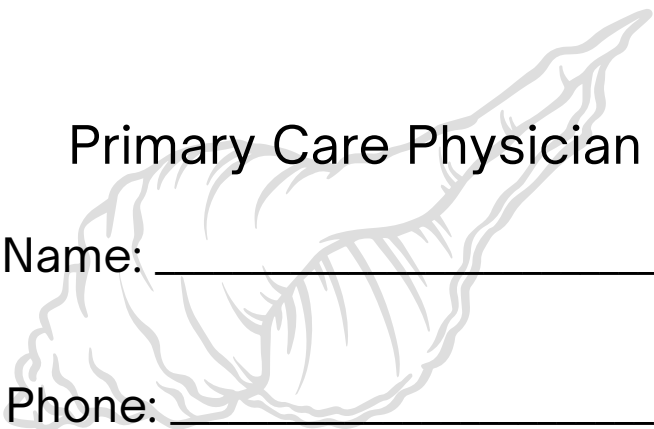
Pharmacy :

Name: \_\_\_\_\_

Name : \_\_\_\_\_

Phone: \_\_\_\_\_

Address : \_\_\_\_\_



## PERMISSION TO CONSENT FOR MEDICAL/OPTOMETRIC CARE TO MINOR CHILD OR INCAPACITATED ADULT

The parent(s) or legal guardian of the following minor child or incapacitated adult:

HIPAA requires a separate form for each patient.

### Authorize:

A primary person and an alternate are recommended. Name of authorized person, address and phone number.

Primary : \_\_\_\_\_

Alternate : \_\_\_\_\_

to consent to an examination which may include dilation, contact lens fitting (including contact lens class and all subsequent follow-ups), vision therapy (VT follow-ups), diagnosis and/or treatment to be rendered to the patient on the advice of any Optometrist licensed to practice Optometry.

This authorization shall be effective from the date signed through \_\_\_\_--\_\_\_\_,20\_\_\_\_, which must not exceed six(6) months from the date signed.

### Signatures:

The signature and consent of one parent is sufficient. Guardian:  
please attach copy of Letters of Guardianship.

Parent/Gardian \_\_\_\_\_

Date \_\_\_\_\_

# Medical History (Please list all below)

None

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## Eye History (Please list all below)

None  Wears Glasses

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## Surgeries (If any)

None  See attached

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## Medications

None  See attached

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## Allergies

None

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### HIPAA Authorization :

I authorize Melbourne Eye to use and disclose my health information for treatment, payment, and healthcare operations.

### Authorized Contacts (Optional) :

List anyone allowed to receive your medical information:

- 1)
- 2)
- 3)

None / Do not share my information

### Patient Rights :

- I understand I may revoke this authorization at any time
- Refusal does not affect my ability to receive care

### Final Signature :

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Thank you for choosing Melbourne Eye!

