CONSENT TO TREAT MINOR

Patient's Name: ____ Date of Birth: _______________

Name of Authorized Person/s

Parent/Guardian Name: ____ Parent/Guardian Date of Birth: _____________ Parent/Guardian Phone Number: _________________________________ Parent/Guardian SS Number: ___________________
Parent/Guardian Name: ____ Parent/Guardian Date of Birth: _____________ Parent/Guardian Phone Number: _________________________________ Parent/Guardian SS Number: ___________________
Parent/Guardian Name: ____ Parent/Guardian Date of Birth: _____________ Parent/Guardian Phone Number: _________________________________ Parent/Guardian SS Number: ___________________

I, ____________________________________, the parent or legal guardian of ______________________________ authorize OCEAN EYE to evaluate and treat him/her. I consent to any medical and/or routine vision care as determined to be necessary for the welfare of my child. I further agree that any charges incurred regardless of insurance coverage are my responsibility and are subject to insurance plan benefits and limitations.

Allergies to Drugs or Food: ____

Special Medication or other Pertinent Information: ____

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PLEASE CHOOSE ONE OF THE FOLLOWING –

_____ I give consent for my child to have OPTOS photos taken (39.00 out-of-pocket, not covered by Insurance)
OPTOS is a quick photo of the back of the eye; there are no significant side effects with this procedure.

OR

_____ I give consent for my child to be dilated (No out-of-pocket charge, covered by Insurance)
Dilation drops will leave the patient blurry up close and light sensitive, side effects could last for up to 6 hours

***** An Exam will not be performed without one of the above options selected. *****

This document is effective as of ________________, and will remain effective until further notice or until the patient reaches eighteen years of age.

Parent Name [printed] ____

Signature ____ **Date** ___________________________