CookChildren's.

2020-2021
Alexander Vision Center eye clinic application

Note: please do not complete this form if your child has private insurance or Medicaid. Those families should call the phone number on their child's insurance card to learn more about their vision care coverage and available optometrists and ophthalmologists.

Patient's name | Patient's date of birth | Sex

Father's name | Birthdate

Mother's name | Birthdate

Address | Apt #

City | Texas | ZIP code

Home phone | Other phone

Parent's email address

Dependents (do not include those listed above)

Name | Age | Sex | Name | Age | Sex

Name | Age | Sex | Name | Age | Sex

Name | Age | Sex | Name | Age | Sex

Income (list monthly income before taxes)

Father's employer | Phone | Monthly salary

Mother's employer | Phone | Monthly salary

Other salary

What is your child's vision problem?

Has your child been a patient at the eye clinic before? | If so, when?

Has your child had eye care at any location? | If so, where?

Who is your child's eye doctor?

Who referred you to the clinic? Name | Title

School or other agency | This person's email

Referral phone | Child's acuity at screening | Right | Left

Other concerns

For clinic use only

Date received

Screened by

Approved | Denied

Signature of parent/guardian and nurse

*Children covered for vision care services by private insurance or Medicaid are not seen in the Alexander Vision Center eye clinic.

Mail or fax to Alexander Vision Center eye clinic • 321 S. Henderson St. • Fort Worth, TX 76104
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