

**SIGHT FOR LIFE**

**MINOR APPLICATION FORM**

Date \_\_\_\_\_

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Date of Birth \_\_\_\_\_

Parent/Guardian Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Street Address \_\_\_\_\_

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

Phone Number: Home \_\_\_\_\_ Work \_\_\_\_\_

Social Security Number \_\_\_\_\_ Birth Date \_\_\_\_\_

Employer \_\_\_\_\_ Number of Years \_\_\_\_\_

Supervisor \_\_\_\_\_ Phone Number \_\_\_\_\_

Spouse Name \_\_\_\_\_ Spouse Birth Date \_\_\_\_\_

Spouse Employer \_\_\_\_\_ Number of Years \_\_\_\_\_

Hourly wage/monthly income \_\_\_\_\_ Spouse's income \_\_\_\_\_

Additional sources of income/month \_\_\_\_\_

-i.e. alimony, palimony, disability, Social Security, etc.

Name and Age of Dependents \_\_\_\_\_ Age \_\_\_\_\_

\_\_\_\_\_ Age \_\_\_\_\_

\_\_\_\_\_ Age \_\_\_\_\_

Do you RENT \_\_\_\_\_ or OWN \_\_\_\_\_ your home?

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What is your monthly rent/mortgage? \_\_\_\_\_

Do you have any other assets (include current value)? \_\_\_\_\_

\_\_\_\_\_  
-i.e. cars, boats, land, stocks, bonds, etc.

Please describe the patient's eye condition in detail \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Is the patient being treated by a doctor? If so, whom?

\_\_\_\_\_

Has the patient been seen by an optometrist or ophthalmologist? If so, whom?

\_\_\_\_\_

When was the patient last examined by this eye doctor?

\_\_\_\_\_

I attest that all of the above information is true and accurate. I understand that if any of this information is falsified, services will be terminated by the Foundation, and I will be liable for any costs incurred or previous services rendered by *Sight for Life*.

Parent /Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Please return this application to:

*Sight for Life*

10624 S. Eastern Ave.

Suite A, #623

Henderson, NV 89052

Or by fax to 702-492-6978