Welcome To Our Office

Today's Date:

This form has been developed specifically for Preschool and School Age Children

Patients' Name: ____ Date of Birth: __________ Age: ______
Address____________________________________City______________________State____ Zip______
Home Phone:(____) __________________ Parent's Work Phone / Cell Phone: (____) _________________
Email Address: ___________________________________
***Would you like to receive emails reminding you of appointments?* ◘ Yes ◘ No**
Were you referred to our office? Friend/Relative (please name) ___________________________________
Student's Grade: _______ School: ____

PLEASE CHECK OFF THOSE THAT APPLY TO YOUR CHILD:

PHYSICAL APPEARANCE OF EYES	**Yes**	**No**	**EYE TEAMING**	**Yes**	**No**
One Eye Turns			Repeats letters within words		
Reddened Eyes or Lids			Frequent Squinting		
Eyes Tear Excessively			Covers one eye when reading		
Encrusted Lids			Tilts head while working at desk		
Frequent Styes on Lids			Odd posture while working at near		
COMPLAINTS			**EYE HAND COORDINATION**		
Headaches			Poor handwriting		
Burning or itching after close work			Repeatedly confuses left - right directions		
Seeing Double			**OTHER**		
Print blurs after reading for a short time			Itchy Eyes		
Words move or "swim"			Burning Eyes		
BEHAVIORAL SIGNS			Eye Pain or Soreness		
Head turns as reading across a page			Feels Like Something In Eyes		
Loses place frequently during reading			Light Sensitivity / Glare Trouble		
Needs finger or marker to keep place			Dry Eye		
Short attention span when reading			Loss of Side (Peripheral) Vision		
Rereads or skips lines			Tired Eyes		
Frequent rubbing or blinking eyes			Other:		

Does your child have any allergies? Yes or No. If so, to what: ____________________________
Is your child taking any medication? Yes or No. If so, what: ________________________________
Does your child wear glasses? Yes or No If yes, how old is that pair of glasses? ________
Does your child wear contact lenses? Yes or No If yes, how old is that pair of lenses? _________
Type of contact lenses: Rigid Soft Extended Wear
Are they comfortable? Yes or No
What contact lens cleaning solution does your child use? _________________________________
Does your child have any contact lens solution sensitivities? _________________________________

Are you planning to get new glasses today? Yes No Only if Prescription Changes
Are you planning to get new contact lenses today? Yes No Only if Prescription Changes

EYE AND HEALTH HISTORY/REVIEW OF SYSTEMS

Please note any conditions (Self, Parents, Grandparents and Siblings):

EYE DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	◘	◘	◘	______________
Cataract	◘	◘	◘	______________
Crossed Eyes	◘	◘	◘	______________
Eye Surgery/Infection/Injury	◘	◘	◘	______________
Glaucoma	◘	◘	◘	______________
"Lazy Eye"	◘	◘	◘	______________
Macular Degeneration	◘	◘	◘	______________
Retinal Detachment/Disease	◘	◘	◘	______________

HEALTH CONDITION/DISEASE	NO	YES	?	RELATIONSHIP TO YOU
Cancer	◘	◘	◘	______________
Skin (Integumentary)	◘	◘	◘	______________
Vascular/Cardiovascular				
Diabetes	◘	◘	◘	______________
Heart Disease	◘	◘	◘	______________
High Blood Pressure	◘	◘	◘	______________
High Cholesterol	◘	◘	◘	______________
Lupus	◘	◘	◘	______________
Stroke	◘	◘	◘	______________
Genitourinary				
Genitals/Kidney/Bladder	◘	◘	◘	______________
Gastrointestinal				
Diarrhea	◘	◘	◘	______________
Constipation	◘	◘	◘	______________
Constitutional				
Fever, Weight Loss/Gain	◘	◘	◘	______________
Neurological				
Headaches	◘	◘	◘	______________
Migraine	◘	◘	◘	______________
Seizures	◘	◘	◘	______________
Psychiatric	◘	◘	◘	______________
Endocrine				
Thyroid/Other Glands	◘	◘	◘	______________
Ears/Nose/Mouth/Throat				
Allergies/Hay Fever	◘	◘	◘	______________
Dry Throat/Mouth	◘	◘	◘	______________
Respiratory				
Asthma	◘	◘	◘	______________
Emphysema	◘	◘	◘	______________
Bones/Joints/Muscles				
Rheumatoid Arthritis	◘	◘	◘	______________
Joint/Muscle Pain	◘	◘	◘	______________
Lymphatic/Hematologic				
Anemia	◘	◘	◘	______________
Bleeding Problems	◘	◘	◘	______________
Allergic/Immunologic	◘	◘	◘	______________
Other ________________	◘	◘	◘	______________

<u>OFFICE FINANCIAL RESPONSIBILITY</u>

- Payment in full is due at the time of service unless an arrangement has been made prior to your scheduled appointment. ***We accept cash, check, Visa, MasterCard, American Express and Discover*.**
- All checks returned by the bank for insufficient funds will incur a $25.00 bank fee. After we notify you, you have seven days to remit payment in full, plus the additional $25.00. Failure to do so will result in your account being turned over to a collection agency.
- I understand that should my account balance become 30 days past due my account will begin to accrue interest calculated at 1.5% monthly (18% per annum). I also understand that if the office is required to place my account with a collection agency or attorney for collection, I agree to be responsible for all costs incurred in the collection of my account, including attorney's fees, interest from the initial statement date (1.5% monthly, 18% per annum) and all incurred costs in collecting the amount owed.
- We require full payment for materials (glasses and contact lenses) at the time the order is placed.
- I understand that if I require a **referral** for my major medical insurance I am responsible for arriving with the referral from my Primary Care Physician (PCP) or I will be responsible for paying in full for all services rendered at the time of the examination.
- I understand that all patients wearing contact lenses receive tests and follow-up care above and beyond a comprehensive exam. This contact lens medical evaluation is performed every 12 months whether or not new contact lenses are purchased. I understand there is an additional charge for this service. Most insurance companies consider contact lenses "cosmetic" and not "medically necessary;" therefore, **services related to contact lenses** are not covered and will be my responsibility.
  If you do not wish to incur any contact lens charges, please inform our staff **before** your examination and remove your contact lenses before your examination begins. However, if this is your choice we will not be able to dispense any contact lenses to you, write a prescription for contact lenses, or be responsible for any contact lenses you might continue to wear.
- I acknowledge that during the course of the examination, the Doctor may request further specialized tests due to medical history, family history or to better diagnose any potential eye health problems. In many cases these tests are covered by your major medical plan. If your plan should not cover the recommended testing these charges will be your responsibility and due at the time of your appointment.
- As your eye care provider it is our responsibility to provide you and your family with the best possible health care. Please remember, your insurance policy is an agreement arrived at between you and your insurance company and not between your insurance company and your provider. Each insurance company has dozens of plans; all different. It is impossible for our staff to have complete knowledge of each one. **For our insurance patients**:
  - *If you plan to use your insurance as a form of payment* you must present a current insurance ID card to our staff no later than at the time of your appointment; if your **vision plan** is not listed on your major medical insurance card you must inform us of the vision plan's name so we can research and determine your coverage. If you have not presented your insurance information prior to the completion of your examination ***we will not be able to provide refunds, order cancellations or adjustment to fees AFTER your order has been placed and initial services have been rendered,*** however, we will help you submit your claim for reimbursement.
  - Although we pre-authorize services and materials prior to your arrival, we are told by your insurance company that they will not guarantee payment of the claim until they have processed your individual claim. If your insurance company declines the claim submitted, you will be responsible for the balance owed.
  - If your deductible has not been met, your visit will not be covered by your insurance company and you **will** be charged today. We will file the claim with your insurance company so that the amount you paid today is credited toward your deductible amount.
  - Co-payments are due at the time of your visit.
- If there are any questions concerning your bill, either today or when received by mail, it is your responsibility to ask. If we do not hear from you we will assume that you understand, and agree to pay the charges listed.
- *Your signature indicates that you have read, understand and agree to all of the above policies.*

Signature: ____ Date: ____________________

(Person Responsible for the Account)