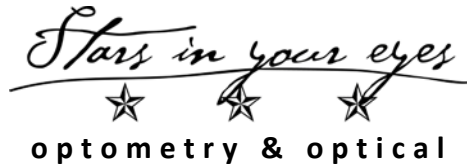


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## YOUR CHILD'S PATIENT INFORMATION FORM

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

Were you referred to our office? Yes  No  If "Yes," whom may we thank for this referral? \_\_\_\_\_

If not Referred, how did you hear about us? \_\_\_\_\_

### GENERAL INFORMATION

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Male  Female  Home Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Mother/Caretaker's Name: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Father/Caretaker's Name: \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### INSURANCE INFORMATION

Does the patient have **VISION INSURANCE COVERAGE**? Yes  No  If "Yes," complete the following:

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

Primary Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_

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

Does the patient have **MEDICAL INSURANCE COVERAGE**? Yes  No  If "Yes," complete the following:

Insurance Company: \_\_\_\_\_ Primary ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Primary Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_

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

If you have medical insurance we are anxious to help you receive your maximum benefit. To do so, we need your assistance and your understanding of our payment policy. We will file your insurance claim form for you, however, we ask that you pay any co-payment or deductibles at the time the services are rendered and the balance in full if insurance has not paid within thirty days. We will do all we can to expedite insurance reimbursement, but you must realize that: (1) Your insurance is a contract between you, your employer, and the insurance company. We may not be a party to that contract. (2) Our fees fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. Any non-allowed amount is your responsibility. (3) Not all services are a covered benefit in all contracts. Insurance companies arbitrarily select certain services they will not cover. These non-covered services are your responsibility. (4) Pre-authorization of procedures may be required. This is your responsibility.

Your responsibilities are to: (1) present your insurance card at check-in, (2) pay your deductible or co-payment at the time services are rendered, and (3) pay for any non-covered services.

I understand and accept the financial policy of Stars In Your Eyes. Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### YOUR CHILD'S MEDICAL HISTORY

Pediatrician's Name: \_\_\_\_\_ Is your child especially afraid of doctors? Yes  No

Last Visit Date: \_\_\_\_\_ For what reason? \_\_\_\_\_ Is your child generally healthy? Yes  No

Medications (include vitamins/supplements): \_\_\_\_\_

Does your child receive immunizations? Yes  No  Are they up-to-date? Yes  No

List significant illnesses, bad falls, high fevers or chronic illnesses (asthma, allergies, frequent colds, ear infections)

Event/Condition	Age	Severity	Describe any complications

**YOUR CHILD'S FAMILY HISTORY** (Please check the boxes to indicate if there is any history of the following conditions.)

	<u>Patient</u>	<u>Family</u>	<u>If Family, Who?</u>		<u>Patient</u>	<u>Family</u>	<u>If Family, Who?</u>
Poor Vision/Hi Rx	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strabismus/ eye turn	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning Issue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

**YOUR CHILD'S VISUAL HISTORY**

Has your child's vision been previously evaluated? Yes  No  If "Yes," Dr. Name: \_\_\_\_\_ Date: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Does your child wear: Glasses  Contacts  Both  Worn for which activities? \_\_\_\_\_

Has your child failed a school vision screening? Yes  No  Does your child have academic difficulties? Yes  No

Check all that apply:  Reading/Reading Comprehension  Writing  Increased Time To Do Homework  Behavioral Issue  
 Not Working Up To Potential  Dyslexia  ADD/ADHD Other: \_\_\_\_\_

Does your child report any of the following symptoms?	Yes	No	If "Yes," explain.
Eyes Hurt	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches (please note time of day they occur)	<input type="checkbox"/>	<input type="checkbox"/>	
Blurred Vision / Focus Goes In and Out	<input type="checkbox"/>	<input type="checkbox"/>	
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes Tired	<input type="checkbox"/>	<input type="checkbox"/>	
Sensitive to Bright Light/Sunlight	<input type="checkbox"/>	<input type="checkbox"/>	
Motion Sickness/Car Sickness	<input type="checkbox"/>	<input type="checkbox"/>	
Words Appear to "Swim" or Move when Reading/Writing	<input type="checkbox"/>	<input type="checkbox"/>	

List any other complaints your child makes concerning his/her vision: \_\_\_\_\_

Do you notice any of the following symptoms in your child?	Yes	No	If "Yes," explain.
Red, Watery or Itchy Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent Styes	<input type="checkbox"/>	<input type="checkbox"/>	
Tendency to Rub Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Excessive Blinking or Squinting	<input type="checkbox"/>	<input type="checkbox"/>	
Frowning/ Wrinkled Forehead/Face Tension	<input type="checkbox"/>	<input type="checkbox"/>	
An Eye that Turns In/Out	<input type="checkbox"/>	<input type="checkbox"/>	
Covers/Closes One Eye when Doing Near Tasks	<input type="checkbox"/>	<input type="checkbox"/>	
Move Objects Very Close to Look at Them	<input type="checkbox"/>	<input type="checkbox"/>	
Uses Finger as Marker to Read	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with Long Periods of Reading/Writing	<input type="checkbox"/>	<input type="checkbox"/>	
Avoids Reading	<input type="checkbox"/>	<input type="checkbox"/>	
Loss of Place When Reading	<input type="checkbox"/>	<input type="checkbox"/>	
Confuses "Left" and "Right"	<input type="checkbox"/>	<input type="checkbox"/>	
Clumsy or Uncoordinated	<input type="checkbox"/>	<input type="checkbox"/>	

List any other Visual Symptoms that you notice: \_\_\_\_\_