# Children's Eye Center - Confidential Patient Information

**Welcome to our office.**

**Exam Date:____/____/____**

**Patient's Full Name:**________________________________________ **Nickname:**_______________

**Street:**_____________________________________________ **Apt#:**________

**City:**____________________________ **State:** Wisconsin_________ **Zip code:**_______________

**Home Phone:** (_____) _______-_____________ **Cell Phone:** (_____) _______-_______________

**Sex of patient:** ☐ Male ☐ Female

**Age:** _____________ **Date of birth:** ____/_____/_____ **School grade:**________________

**Adult strabismus patients only:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

**Occupation:**________________________________________

**Pediatrician/ Family Physician:**

________________________________________

Office Address:

________________________________________

________________________________________

________________________________________

Office Phone: ( ) -

**Other physicians to receive a report:**

Name:______________________________

Specialty:____________________________

Address:_____________________________

________________________________________

________________________________________

Office Phone: ( ) -

**Were you referred to us by your pediatrician or family physician?** ☐ Yes ☐ No

**If "No"**, who referred you, or how did you hear of us?

## *This section for our Pediatric Patients under age 18 only*

1. **Patient lives with** ☐ both parents ☐ mother ☐ father ☐ relative ☐ guardian
2. **Parents are** ☐ married ☐ separated ☐ divorced ☐ single ☐ widowed

**Full name of Father (or Guardian):**______________________________ Date of Birth ___/___/_____

Occupation:_________________ Cell phone: (____)_____-_______ SS # _____-_____-_______

Work phone:(____)_____-_______

**Full name of Mother (or Guardian):**______________________________ Date of Birth ___/___/_____

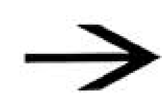
Occupation:_________________ Cell Phone: (____)_____-_______ SS # _____-_____-_______

Work phone:(____)_____-_______

**Name and ages of brothers and sisters:**________________________________________

**List names of other family members who are patients of Dr. Patterson**____________________

**PLEASE complete other side**



**All services may not be covered under your medical insurance**. Most pediatric eye diseases referred by your primary physician will fall under your medical insurance coverage. However, please be aware that routine vision care may not be covered under your medical policy. Routine vision care assumes poor vision is due only to a need for glasses such as nearsightedness or astigmatism. A normal eye exam may also be considered routine vision care by your medical insurance policy.

We will file your claim with your medical insurance company. We do not have contracts with vision plans and cannot file vision insurance claims. You may file your receipt with your vision plan should you require reimbursement for a routine vision exam.

Please contact our office, your employer or your insurance company if you have any questions about your insurance benefits.

## Please read and sign below

### Authorization for Treatment and Release of Information

I allow the Children's Eye Center to evaluate and treat the above named patient and to release any information from my exam or treatment to my insurance company and to receive all payments for such examination and treatment. Children's Eye Center has my permission to release any diagnostic studies, reports, etc. to my primary care physician and I authorize any physician, hospital, or medical facility to provide all information in my medical history to Children's Eye Center.

### Payment Policies

Charges for your eye exam and other testing will be submitted to your insurance company on your behalf. Payment for co-pays and non-covered services is due at the time of your visit. All returned checks will be subject to a service charge. A $25 no-show fee will be charged for all missed appointments without 24 hours notice of cancellation.

All insurance information must be received by the Children's Eye Center within **3 days** of the service date. If the insurance information is not received, the charges will become your responsibility.

I understand that I am responsible for payment of my insurance deductible and all services not paid by my insurance company. All accounts are due in full within 30 days. Accounts transferred to a collection agency will be subject to a service charge.

**In divorce situations, the parent that brings the child to the appointment is responsible for payment of charges including co-payments, regardless of divorce decree. If payment issues exist, they must be resolved between the parents.

I acknowledge that I have received the Notice of Privacy Practices.

**Parent (patient) signature:**______________________________ Date: _____/_____/_____

### PLEASE READ AND SIGN CONSENT FOR DILATING DROPS

You or your child may require safe, dilating eye drops for your eye exam today. Dilating the pupils is often necessary to provide an accurate diagnosis. The vision is blurred and the eyes are sensitive to the sun for 3-4 hours but dilation may last up to 2 days in rare cases. Reading vision may be impaired and driving may be difficult.

**Parent (patient) signature:**______________________________ Date:_____/_____/_____

**Please complete next page**

# Patient's Medical History

PATIENT NAME:______________________________ TODAY'S DATE:____/____/____

Name of person completing form for pediatric patients:__________________ Relationship to patient:______________

**HISTORY OF EYE PROBLEMS:**

1. What problem(s) is your child (or adult patient) having with their eyes?____________________________

2. Has your child (or adult patient) ever had any eye problems, patching treatment or surgery? Please be specific with approximate dates and the treating doctor/clinic.____________________________

3. When was your child's (or adult patient's) last eye exam?_________ Who was the doctor or where?______________

4. Does your child (or adult patient) wear glasses? Yes ☐ No ☐ If yes, how long?______________

5. Does your child (or adult patient) wear contact lenses? Yes ☐ No ☐ If yes,what brand?______________

**RECENT EYE SYMPTOMS:**

| YES | NO | | IF YES, WHICH EYE? |
|---|---|---|---|
| ☐ | ☐ | Blurred vision | |
| ☐ | ☐ | Double vision | |
| ☐ | ☐ | Glare/light sensitivity | |
| ☐ | ☐ | Burning | |
| ☐ | ☐ | Itching | |
| ☐ | ☐ | Pain or soreness | |
| ☐ | ☐ | Excess tearing | |
| ☐ | ☐ | Mucous discharge | |
| ☐ | ☐ | Redness | |
| ☐ | ☐ | Crossed or wandering eye | |

***FAMILY* HISTORY:** Do the patient's **relatives** have any of the following?

| YES | NO | | IF YES, WHO? |
|---|---|---|---|
| ☐ | ☐ | Blindness | |
| ☐ | ☐ | Retinal detachment | |
| ☐ | ☐ | Genetic eye disease (runs in the family) | |
| ☐ | ☐ | Amblyopia (bad vision in one eye) | |
| ☐ | ☐ | History of patching treatment | |
| ☐ | ☐ | Strabismus ("crossed or wandering eye") | |

**At what age** did your child's birth parents begin wearing glasses? Mother _____ Father _____

**SOCIAL HISTORY for adult strabismus patients only:** Do you smoke? Yes ☐ No ☐
Do you drink alcohol? Yes ☐ No ☐

**MEDICAL HISTORY AND REVIEW OF SYSTEMS:**

| YES | NO | | IF YES, EXPLAIN BELOW |
|---|---|---|---|
| ☐ | ☐ | Frequent headaches | |
| ☐ | ☐ | Asthma | |
| ☐ | ☐ | Frequent ear infections | |
| ☐ | ☐ | Other ear, nose or throat problems | |
| ☐ | ☐ | Attention Deficit Disorder | |
| ☐ | ☐ | Reading problems/learning disability | |
| ☐ | ☐ | HIV or AIDS | |
| ☐ | ☐ | Fever or weight loss | |
| ☐ | ☐ | Heart problems | |
| ☐ | ☐ | Lung disease | |
| ☐ | ☐ | Stomach or intestinal disease | |
| ☐ | ☐ | Kidney or urinary disease | |
| ☐ | ☐ | Skin disease | |
| ☐ | ☐ | Neurologic(brain) problems | |
| ☐ | ☐ | Mental illness | |
| ☐ | ☐ | Cancer | |
| ☐ | ☐ | Genetic diseases in family | |
| ☐ | ☐ | Blood disorder (anemia, etc.) | |

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1. **LIST** any previous surgery, hospitalizations, major illnesses, or injuries (other than eye problems):____________________________

2. **LIST** all medications and eye drops:____________________________

3. **LIST** allergies to medicines ☐ NONE ____________________________

4. **Birth history for patients 10 years old or younger:** Birth weight : ____ lbs ____ ounces
   Length of pregnancy: ☐ Full term ☐ Premature- length of pregnancy: ____ weeks
   **LIST** any problems with pregnancy:____________________________