Children's Eye Center - Confidential Information

Welcome to our office.

Exam Date: ____/____/____

Patient's Full Name:_____ **Nickname**: _____

Patient's Address:_____ **Apt#**: _____

City:_____ **State:** Wisconsin_____ **Zip Code**:_____

Email Address:_____@_____ **Circle**: Mom Dad

Home Phone:(____) ____-_____ **Mom Cell Phone:** (____) ____-_____

Sex of patient: ☐ Male ☐ Female **Dad Cell Phone:** (____) ____-_____

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 ☐legal guardian ☐foster parent

2.**Parents are** ☐married ☐separated ☐divorced ☐single ☐widowed

Father's full name (or Guardian): _____ **Date of Birth** ____/____/____

Father's Address: ☐ Same as above

_____

_____

Occupation:_____

Work phone: (____) ____-_____

Mother's full name (or Guardian): _____ **Date of Birth** ____/____/____

Mother's Address: ☐ Same as above

_____

_____

Occupation:_____

Work phone: (____) ____-_____

Names 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 are medical conditions that 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. Patient exams with a medical eye diagnosis cannot be submitted as routine vision care.

Your claim will be submitted to your medical insurance company. Our office is not contracted with vision plans and cannot file vision insurance claims. You may send your receipt to your vision plan for reimbursement.

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 or specialist 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 all non-covered services is due at the time of your visit or procedure. Effective September 1, 2016, a $25 Administrative Fee will be added to accounts when co-pays are not paid at the time of service. All returned or lost checks will be subject to a service charge. A $50 no-show fee will be applied to your account for missed appointments without 24 hours notice.

All insurance information must be received by the Children's Eye Center within **3 business 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 are subject to a service charge.

***In divorce situations, the parent who brings the child to the appointment is responsible for payment of charges including copays, *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 dilating eye drops for your eye exam today. Dilating the pupils is usually 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	

YES	NO		IF YES, WHICH EYE?
☐	☐	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)	

YES	NO		IF YES, WHO?
☐	☐	Amblyopia (poor 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	

YES	NO		IF YES, EXPLAIN BELOW
☐	☐	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:_____