Pediatric Ophthalmology, P.A.—Minor

Dallas-214-369-6434 6200 W Parker Rd 972-981-8430 15th & Coit 972-758-0625 Grapevine 817-329-5433

PATIENT NAME ____________________ Male or Female
DATE of BIRTH ______/______/________ SS# ____________________
STREET____________________CITY__________STATE______ ZIP __________
HOME PHONE_____/_____/________ ADDITIONAL PHONE ________/______/________
PEDIATRICIAN/PHYSICIAN____________________ REFERRING PHYSICIAN____________________
PHONE ________/______/________ PHONE ________/______/________

Parents/Legal Guardians

PLEASE COMPLETE FOR *BOTH* PARENTS

MOTHER'S NAME____________________
SS # ______________DOB____/___/______
ADDRESS____________________
____
HOME PHONE_____/_____/__________
EMPLOYER____________________
WORK PHONE_____/_____/__________
CELL PHONE ______/_____/__________
E-Mail Address ____________________

FATHER'S NAME____________________
SS#:____________________ DOB___/___/________
ADDRESS____________________
____
HOME PHONE _____/____/__________
EMPLOYER____________________
WORK PHONE_______/______/__________
CELL PHONE ______/______/__________
E-Mail Address ____________________

Insurance Information

Copy of card(s) will be taken

PRIMARY INSURANCE
Insurance Name:____________________
Policy Number:____________________
Group Number: ____________________
Subscriber Name: ____________________
Subscriber DOB: _______/_______/________
Subscriber SS#: ____________________
Relationship to Patient: ____________________

SECONDARY INSURANCE
Insurance Name:____________________
Policy Number: ____________________
Group Number: ____________________
Subscriber Name: ____________________
Subscriber DOB: _________/_________/________
Subscriber SS#: ____________________
Relationship to Patient: ____________________

Insurance Authorization and Assignment

I hereby authorize my insurance carrier(s), including Medicare to issue payment directly to Pediatric Ophthalmology, P.A., for medical services rendered to myself and/or my dependent regardless of my insurance benefits. I understand that I am responsible for any amount not covered by insurance.

I hereby authorize Pediatric Ophthalmology, P.A., to: (1) release any information to insurance carrier regarding my illness and treatment (2) to process claims generated in the course of examination, or treatment, and (3) to allow a photocopy of my signature to be used to process insurance claims.

____________________ ____________________
Signature Parent/Legal Guardian Date

Authorization

I hereby give my consent to the physicians and other clinical personnel of Pediatric Ophthalmology for the evaluation and treatment of my minor child on an ongoing basis.

I understand that I have the right to revoke this consent in writing, at any time, except when the physicians or other clinical personnel have already taken action on my consent.

I am responsible for co-payments, deductibles, and non covered services at time of service.

____________________ ____________________
Parent/Legal Guardian Date

REASON FOR VISIT: (Important, please complete)

Patient History **(natural ___, adopted _____)**

History of Eye Problems:

Yes	No			
☐	☐	Glasses	How old is current pair?	________
☐	☐	Contact Lens	How old is current pair?	________
☐	☐	Prisms	How long?	________

Yes	No	Past Ocular History	Age	Yes	No	Past Ocular History	Age
☐	☐	Eye exam by specialist	________	☐	☐	Other eye surgery	________
☐	☐	Amblyopia	________	☐	☐	Eye injury	________
☐	☐	Patching or dilating drops	________	☐	☐	Recurring "pink eye"	________
☐	☐	Eye exercises	________	☐	☐	Cataract	________
☐	☐	Misaligned eye	________	☐	☐	Glaucoma	________
☐	☐	Eye muscle surgery	________	☐	☐	Diabetic eye disease	________

Diagnosed eye diseases not mentioned above: ____

Medical History

Yes	No	Condition	Yes	No	Condition
☐	☐	Frequent ear infections	☐	☐	Diabetes
☐	☐	Sinus disease	☐	☐	Anemia
☐	☐	Heart disease	☐	☐	Kidney disease
☐	☐	High blood pressure	☐	☐	Neurologic disease
☐	☐	Asthma	☐	☐	Seizures or stroke
☐	☐	Allergies	☐	☐	Depression
☐	☐	Arthritis	☐	☐	Cancer
☐	☐	Thyroid problem	☐	☐	Other illness no mentioned
☐	☐	Previous surgery or hospitalization:			________

Medications

Eye drop and frequency	Why is this medication being used:

Medication and dosage	Why is this medication being used:

List any known allergies to medication ☐ None

Birth history (Pediatric patients only) Birth weight: ________**lb** _______**oz.**

Yes	No	Condition	Please provide details
☐	☐	Problems in pregnancy	Describe:
☐	☐	Problems in delivery	Describe:
☐	☐	Forceps delivery	
☐	☐	Cesarean section	
☐	☐	Delivered early	
☐	☐	Delivered late	
☐	☐	Baby kept in hospital due to illness	Why and how long?
☐	☐	Delay in sitting, walking, talking or development	Describe:
☐	☐	Any outstanding school diffculties	Describe:

Family History

Sibling names ____

____

Names of siblings seen at this practice ____

Yes	No	Eye Conditions in other family members:	Which relative? (circle one)
☐	☐	Glasses before age 6	Father Mother Sister Brother Other
☐	☐	Amblyopia ("lazy eye")	Father Mother Sister Brother Other
☐	☐	Patching treatment	Father Mother Sister Brother Other
☐	☐	Strabismus (crossed or wandering eye)	Father Mother Sister Brother Other
☐	☐	Eye muscle surgery	Father Mother Sister Brother Other
☐	☐	Cataracts	Father Mother Sister Brother Other
☐	☐	Glaucoma	Father Mother Sister Brother Other
☐	☐	Blindness	Father Mother Sister Brother Other
☐	☐	Other serious eye disease (describe)	________

Received by:	Date: