

**PEDIATRIC OPHTHALMOLOGY, P.A.**

Dallas 214-369-6434

6200 W Parker Rd 972-981-8430

15th & Coit 972-758-0625

Grapevine 817-329-5433

<b>This section for all patients: PLEASE PRINT</b>	
Patient's Name (Legal):	Sex: Female Male
Date of Birth:	_____
Social Security Number:	_____
Mailing Address:	_____
Home Phone:	_____
Cell Phone:	_____
Employer's Name:	_____
Employer Address:	_____
Business Phone:	_____
Family Physician (or Pediatrician):	_____
Address:	_____
Phone:	_____
Referring Physician:	_____
Address:	_____
Phone:	_____
Referred by: Yellow Pgs - Friend - Physician - Internet	_____
Emergency Contact:	_____
Phone:	_____

<b>Minor patients must complete this section also.</b>	
Family Status: Patient is living with parents. Living with relative, guardian, or foster parents	
Parents are: Married Separated Divorced	
Full Name of Father (or Guardians):	
Social Security Number: _____	
Date of Birth: _____	
Home Address: _____	
Home Phone:	Cell #:
Employer:	_____
Employer Address:	_____
Business Phone: _____	
Full Name of Mother (or Guardian):	
Social Security Number: _____	
Date of Birth: _____	
Home Address: _____	
Home Phone:	Cell #:
Employer:	_____
Employer Address:	_____
Business Phone: _____	
Names and ages of brothers and sisters:	
_____	
_____	
List member(s) of Family seen in practice.	
_____	
_____	

**INSURANCE INFORMATION**

Name of Insured:	_____	Relationship to patient:	_____
Birth date:	_____	Social Security #:	_____
Name of employer:	_____	Work phone #:	_____
Insurance Name:	HMO/PPO/PCS	Group #:	_____
Insurance Co. Address:	_____	City:	State: Zip:

**DO YOU HAVE ADDITIONAL INSURANCE NO YES IF YES, PLEASE COMPLETE THE FOLLOWING:**

Name of insured:	_____	Relationship to patient:	_____
Birth date:	_____	Social Security #:	_____
Name of employer:	_____	Work phone #:	_____
Insurance Name:	HMO/PPO/PCS	Group #:	_____
Insurance Co. Address:	_____	City:	State: Zip:

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I hereby assign and authorize my insurance carrier(s), including Medicare to issue payment (checks) directly to Pediatric Ophthalmology, P.A. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. 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 carriers regarding my illness and treatments; 2) to process claims generated in the course of examination or treatment; and 3) to allow a photocopy to my signature to be used to process insurance claims.

Signature

Date

Physician being seen:

Registration Clerk:     COMPLETE BACK

Adult Strabismus and Pediatric Ophthalmology - New Patient Questionnaire

REASON FOR VISIT:
-------------------

History of Eye Problems:

Family History (natural \_\_\_\_, adopted \_\_\_\_)

Yes No

<input type="checkbox"/>	<input type="checkbox"/>	Glasses	How old is current pair? _____
<input type="checkbox"/>	<input type="checkbox"/>	Contact Lens	How old is current pair? _____
<input type="checkbox"/>	<input type="checkbox"/>	Prisms	How long? _____

Yes	No	Past Ocular History	Age	Yes	No	Past Ocular History	Age
<input type="checkbox"/>	<input type="checkbox"/>	Eye exam by specialist	_____	<input type="checkbox"/>	<input type="checkbox"/>	Eye injury	_____
<input type="checkbox"/>	<input type="checkbox"/>	Patching	_____	<input type="checkbox"/>	<input type="checkbox"/>	Stye	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eye exercises	_____	<input type="checkbox"/>	<input type="checkbox"/>	Recurring "pink eye"	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eye muscle surgery	_____	<input type="checkbox"/>	<input type="checkbox"/>	Cataract	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other eye surgery	_____	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	_____
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	Diabetic eye disease	_____

Diagnosed eye diseases not mentioned above:

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

Medical History

Yes	No	Condition	Yes	No	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Sinus disease	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic disease
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or stroke
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>	Other illness no mentioned
<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/> None

Birth history (Pediatric patients only) Birth weight: _____lb _____oz.	
Yes No Condition	Please provide details
<input type="checkbox"/> <input type="checkbox"/>	Problems in pregnancy Describe: _____
<input type="checkbox"/> <input type="checkbox"/>	Problems in delivery Describe: _____
<input type="checkbox"/> <input type="checkbox"/>	Forceps delivery
<input type="checkbox"/> <input type="checkbox"/>	Cesarean section
<input type="checkbox"/> <input type="checkbox"/>	Delivered early
<input type="checkbox"/> <input type="checkbox"/>	Delivered late
<input type="checkbox"/> <input type="checkbox"/>	Baby kept in hospital due to illness Why and how long? _____
<input type="checkbox"/> <input type="checkbox"/>	Delay in sitting, walking, talking or development Describe: _____
<input type="checkbox"/> <input type="checkbox"/>	Any outstanding school difficulties Describe: _____

Received by: _____	Date: _____
--------------------	-------------