

Pediatric Ophthalmology, P.A.—Adult

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6130 W Parker Rd • Plano Tx 75093 972-981-8430

Patient Name _____ Male or Female _____
Street _____ City _____ State _____ Zip _____
Home Phone _____ / _____ / _____ Cell Phone _____ / _____ / _____
Date of Birth _____ / _____ / _____ Social Security # _____
Referring Physician _____
Phone # _____ / _____ / _____ First name _____ Last name _____
Primary Physician (if different) _____
Phone # _____ / _____ / _____ First name _____ Last name _____
Employer _____
Address _____
Work Phone Number _____ / _____ / _____ E-Mail Address _____
Emergency Contact _____ *Phone #* _____ / _____ / _____

Insurance Information Copy of card(s) will be taken

| PRIMARY INSURANCE | SECONDARY INSURANCE |
|---------------------------------------|---------------------------------------|
| Insurance Name: _____ | Insurance Name: _____ |
| Policy Number: _____ | Policy Number: _____ |
| Group Number: _____ | Group Number: _____ |
| Subscriber Name: _____ | Subscriber Name: _____ |
| Subscriber Address: _____ | Subscriber Address: _____ |
| Subscriber DOB: _____ / _____ / _____ | Subscriber DOB: _____ / _____ / _____ |
| Subscriber SS#: _____ | Subscriber SS#: _____ |
| Relationship to Patient: _____ | 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 Patient/Legal Guardian

Date

Authorization

I hereby give my consent to the physicians and other clinical personnel of Pediatric Ophthalmology for my evaluation and treatment 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.

Patient/Legal Guardian

Date

Adult Strabismus and Pediatric Ophthalmology - New Patient Questionnaire

| |
|---|
| REASON FOR VISIT: (Important, please complete) |
|---|

Patient History (natural __, adopted __)

History of Eye Problems:

| 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"/> | Other eye surgery | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Amblyopia | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Eye injury | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Patching or dilating drops | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Recurring "pink eye" | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye exercises | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Cataract | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Misaligned eye | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye muscle surgery | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Diabetic eye disease | _____ |

Diagnosed eye diseases not mentioned above: _____

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: _____ |

Family History

| 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) | _____ |

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