

**Pediatric Ophthalmology, P.A.—Minor**

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6130 W. Parker Rd. #508 • Plano Tx 75093 972-981-8430

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 \_\_\_\_\_ FATHER'S NAME \_\_\_\_\_  
SS # \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
ADDRESS \_\_\_\_\_ ADDRESS \_\_\_\_\_  
HOME PHONE \_\_\_\_/\_\_\_\_/\_\_\_\_ HOME PHONE \_\_\_\_/\_\_\_\_/\_\_\_\_  
EMPLOYER \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
WORK PHONE \_\_\_\_/\_\_\_\_/\_\_\_\_ WORK PHONE \_\_\_\_/\_\_\_\_/\_\_\_\_  
CELL PHONE \_\_\_\_/\_\_\_\_/\_\_\_\_ CELL PHONE \_\_\_\_/\_\_\_\_/\_\_\_\_  
E-Mail Address \_\_\_\_\_ 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
- Contact Lens
- Prisms

How old is current pair? \_\_\_\_\_  
 How old is current pair? \_\_\_\_\_  
 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**

Sibling names \_\_\_\_\_

Names of siblings seen at this practice \_\_\_\_\_

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: \_\_\_\_\_