

Full Name \_\_\_\_\_  
 Nickname \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F  
 Employer/School \_\_\_\_\_  
 Occupation/Grade \_\_\_\_\_  
 Spouse (or Parent's) Name \_\_\_\_\_  
 Children's Names & Ages \_\_\_\_\_  
 SS# \_\_\_\_\_ Work Ph \_\_\_\_\_  
 Home Ph \_\_\_\_\_ Cell Ph \_\_\_\_\_  
 May we contact you by: \_\_\_ Home # \_\_\_ Office #  
 \_\_\_ Cell# \_\_\_ Text \_\_\_ E-mail  
 E-mail Address \_\_\_\_\_

Today's Date \_\_\_\_\_  
 What is the primary purpose of today's visit? \_\_\_\_\_  
 \_\_\_\_\_  
 Last Vision Exam: \_\_\_\_\_  
 Office/Doctor: \_\_\_\_\_

**Current Medications (Rx or Over the counter)**

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**Current Vitamins or Nutritional Supplements**

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

**Allergies to Medications? Y / N**

If so, please list:

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

**IF YOU ARE A NEW PATIENT, PLEASE COMPLETE BELOW.**

**Personal and Family History** (parent, grandparent, sibling, children) Please check any of the following for which you or a family member has a history. List relationship and specifics below.

|  | Self                     | Family                   |                     | Self                     | Family                   |
|--|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|
| Retinal Disease  | <input type="checkbox"/> | <input type="checkbox"/> | Eye Surgery         | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma   | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid             | <input type="checkbox"/> | <input type="checkbox"/> |
| Cataracts  | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis           | <input type="checkbox"/> | <input type="checkbox"/> |
| Macular Degeneration   | <input type="checkbox"/> | <input type="checkbox"/> | Systemic Lupus      | <input type="checkbox"/> | <input type="checkbox"/> |
| Strabismus/Crossed Eye   | <input type="checkbox"/> | <input type="checkbox"/> | Multiple Sclerosis  | <input type="checkbox"/> | <input type="checkbox"/> |
| Amblyopia / Lazy Eye   | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes            | <input type="checkbox"/> | <input type="checkbox"/> |
| ADD/ADHD   | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease       | <input type="checkbox"/> | <input type="checkbox"/> |
| Learning Disability / Dyslexia   | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Autism/PPD   | <input type="checkbox"/> | <input type="checkbox"/> | Migraines           | <input type="checkbox"/> | <input type="checkbox"/> |
| Sensory Integration Issues   | <input type="checkbox"/> | <input type="checkbox"/> | Seizure Disorder    | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Medical Conditions _____   |                          |                          |                     |                          |                          |
| Current State of Health <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |                          |                          |                     |                          |                          |

**Do You...**

Currently wear glasses? Y N For: \_\_\_\_\_  
 Currently wear contacts? Y N  
 If so, what kind \_\_\_\_\_  
 Replacement Schedule \_\_\_\_\_

**Are You...**

Interested in wearing contacts? Y N  
 Interested in Laser Vision Correction? Y N

**Do You...**

Play Competitive Sports? Y N  
 Type(s) \_\_\_\_\_  
 Position(s) \_\_\_\_\_  
 Work on the computer more than 4 hrs/day? Y N  
 Perform other nearwork more than 4 hrs/day? Y N

**Do you experience...**

|   |  |
|---|--|
| <input type="checkbox"/> Redness                | <input type="checkbox"/> Headaches                         |
| <input type="checkbox"/> Spots / Floaters       | <input type="checkbox"/> Nausea                            |
| <input type="checkbox"/> Flashes of light       | <input type="checkbox"/> Dizziness / Imbalance             |
| <input type="checkbox"/> Double vision          | <input type="checkbox"/> Sensitivity to sounds             |
| <input type="checkbox"/> Blurry distance vision | <input type="checkbox"/> Carsickness                       |
| <input type="checkbox"/> Blurry near vision     | <input type="checkbox"/> Fatigue when reading              |
| <input type="checkbox"/> Sudden loss of vision  | <input type="checkbox"/> Inattentiveness                   |
| <input type="checkbox"/> Discomfort in Glasses  | <input type="checkbox"/> Poor Night Vision                 |
| <input type="checkbox"/> Discomfort in Contacts | <input type="checkbox"/> Lack of coordination              |
| <input type="checkbox"/> Glare or Reflection    | <input type="checkbox"/> Difficulty after Car Accident     |
| <input type="checkbox"/> Tearing / Burning      | <input type="checkbox"/> Flicker Sensitivity               |
| <input type="checkbox"/> Dryness                | <input type="checkbox"/> Trouble walking up or down stairs |
| <input type="checkbox"/> Eye Strain             | <input type="checkbox"/> Light Sensitivity                 |
| <input type="checkbox"/> Soreness of eyes       | <input type="checkbox"/> Other                             |
| <input type="checkbox"/> Tinnitus/Ears Ringing  |  |
| <input type="checkbox"/> Itchy Eyes             |  |

**How did you choose our office for your eye care?**

Family / Friend Referral \_\_\_\_\_  
 Professional Referral \_\_\_\_\_  
 Insurance Provider List \_\_\_\_\_  
 Advertisement In \_\_\_\_\_  
 Website \_\_\_\_\_

## Child's Developmental History

CHILD'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_ / \_\_\_ / \_\_\_ AGE: \_\_\_\_\_  
NICKNAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
FATHER'S NAME \_\_\_\_\_ DAYTIME PHONE \_\_\_\_\_  
MOTHER'S NAME \_\_\_\_\_ DAYTIME PHONE \_\_\_\_\_  
SIBLINGS NAMES AND AGES \_\_\_\_\_

### DEVELOPMENTAL & BEHAVIORAL HISTORY

1. Full term pregnancy? \_\_\_\_\_ Normal birth? \_\_\_\_\_
2. Was there anything unusual about your child's early development? \_\_\_\_\_
3. At what age did your child first talk? \_\_\_\_\_
4. Any speech difficulties now? \_\_\_\_\_
5. First walked alone at what age? \_\_\_\_\_
6. Hand preference was clearly indicated at what age? \_\_\_\_\_ R or L or Both (please circle)
7. Are there any indications of hearing problems? \_\_\_\_\_
8. Have there been any significant injuries to your child's head or eyes? \_\_\_\_\_
9. Has a neurological, psychological, speech, or hearing evaluation been performed in the past?

TYPE OF EVALUATION    DATE    BY WHOM    DIAGNOSIS

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### ACADEMIC HISTORY

NAME OF SCHOOL \_\_\_\_\_ CURRENT GRADE \_\_\_\_\_

1. Does your child like school? \_\_\_\_\_ Like teacher? \_\_\_\_\_ Any grades repeated? \_\_\_\_\_
2. Have there been any school difficulties? \_\_\_\_\_
3. Child's favorite subjects? \_\_\_\_\_
4. Child's most difficult subject areas? \_\_\_\_\_

### VISUAL SYMPTOMS AND OBSERVATIONS

|   | YES   | NO    |
|---|-------|-------|
| 1. Vision is blurry at any time .....                             | _____ | _____ |
| 2. Child sees double at any time .....                            | _____ | _____ |
| 3. Complains of fatigue with reading .....                        | _____ | _____ |
| 4. Confusion of similar words or letters .....                    | _____ | _____ |
| 5. Reversals of words or letters when reading or writing .....    | _____ | _____ |
| 6. Poor comprehension .....                                       | _____ | _____ |
| 7. Dislikes reading but likes being read to .....                 | _____ | _____ |
| 8. Rubs eyes during or after reading .....                        | _____ | _____ |
| 9. Closes or covers one eye .....                                 | _____ | _____ |
| 10. Headaches when reading .....                                  | _____ | _____ |
| 11. Holds head too close to desk when writing .....               | _____ | _____ |
| 12. Difficulty copying from chalkboard or book .....              | _____ | _____ |
| 13. Neatness of writing is a problem .....                        | _____ | _____ |
| 14. Slow with written work .....                                  | _____ | _____ |
| 15. Dislikes tasks requiring sustained visual concentration ..... | _____ | _____ |

# Patient Symptom Checklist

Today's Date: \_\_\_\_\_

Full Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Please circle the number in each box that is appropriate:

| Difficulty                            | Never | Seldom | Sometimes | Frequently | Always | Comments |
|---------------------------------------|-------|--------|-----------|------------|--------|----------|
| Anxiety                               | 0     | 1      | 2         | 3          | 4      |          |
| Attention/Concentration Difficulties  | 0     | 1      | 2         | 3          | 4      |          |
| Avoids sports and games               | 0     | 1      | 2         | 3          | 4      |          |
| Emotionality                          | 0     | 1      | 2         | 3          | 4      |          |
| Impulsiveness                         | 0     | 1      | 2         | 3          | 4      |          |
| Loses belongings                      | 0     | 1      | 2         | 3          | 4      |          |
| Auditory Processing Issues            | 0     | 1      | 2         | 3          | 4      |          |
| Clumsy, accident prone                | 0     | 1      | 2         | 3          | 4      |          |
| Coordination Problems                 | 0     | 1      | 2         | 3          | 4      |          |
| Hearing Problems                      | 0     | 1      | 2         | 3          | 4      |          |
| Hyperacusis (Hearing Sensitivity)     | 0     | 1      | 2         | 3          | 4      |          |
| Imbalance/Balance Problems            | 0     | 1      | 2         | 3          | 4      |          |
| Physical Performance Issues           | 0     | 1      | 2         | 3          | 4      |          |
| Photophobia (light sensitivity)       | 0     | 1      | 2         | 3          | 4      |          |
| Speech Difficulties                   | 0     | 1      | 2         | 3          | 4      |          |
| Car or Motion Sickness                | 0     | 1      | 2         | 3          | 4      |          |
| Depression                            | 0     | 1      | 2         | 3          | 4      |          |
| Dizziness/nausea during near work     | 0     | 1      | 2         | 3          | 4      |          |
| Does not judge distances accurately   | 0     | 1      | 2         | 3          | 4      |          |
| Memory Problems                       | 0     | 1      | 2         | 3          | 4      |          |
| Sleep Pattern Challenges              | 0     | 1      | 2         | 3          | 4      |          |
| Difficulty writing in a straight line | 0     | 1      | 2         | 3          | 4      |          |
| Does not count money well             | 0     | 1      | 2         | 3          | 4      |          |
| Headaches with near work              | 0     | 1      | 2         | 3          | 4      |          |
| Inefficient time management           | 0     | 1      | 2         | 3          | 4      |          |
| Omits small words while reading       | 0     | 1      | 2         | 3          | 4      |          |
| Reading comprehension challenges      | 0     | 1      | 2         | 3          | 4      |          |
| Word Retrieval Issues                 | 0     | 1      | 2         | 3          | 4      |          |
| Words appear to run together          | 0     | 1      | 2         | 3          | 4      |          |

TOTAL SCORE=

Have there been a growth spurt / weight gain / loss recently? Yes \_\_\_ No \_\_\_ (please circle all that apply)

**RELEASE OF INFORMATION**

An extensive report will be prepared at the completion of testing and presented to you during the conference. Co-managing with other professionals you are working with is an important way to provide a "total person" integrative approach to treatment.

Under the current HIPAA laws, patients have the right to restrict the uses and disclosure of medical information. By signing this Release of Information Form, you are giving permission to release information to the sources listed below.

I hereby authorize the use or disclosure of \_\_\_\_\_'s  
 (Patient's Name) \_\_\_\_\_(Date of Birth) protected health information and release of records with **Bellaire Family Eye Care** and the **Vision Learning Center** to discuss diagnosis, treatment and progress notes between the professionals listed below.

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email: \_\_\_\_\_

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

## **Bellaire Family Eye Care Notice of Privacy Practices**

Our office is required by law to maintain the privacy of your health information and to provide you with this notice. It describes how your health information can be used and disclosed and how you can access this information.

We will only use and share your health information for the purpose of providing treatment for you and your family or obtaining payment. Your health information will not be used for any other purpose unless we have asked for and been given your written permission.

We promise to use your health information within our office to provide you with the best possible care. This may include office procedures designed to optimize the coordination of the care between the doctors, the technicians, and office staff. In addition, we may share information with referring physicians, pharmacies, and other health care professionals providing your treatment. We may share information with a family member or friend who is involved in your medical care or payment for your care, provided that you agree to the disclosure, or we give you an opportunity to object to the disclosure.

Because we believe regular exams are crucial to maintaining the health of your eyes, we will send out reminders when its time to schedule an appointment. We may also contact you to follow up on your care and inform you of new treatments or services that may be of interest to you and your family. These communications are an important part of our commitment to you and provide the best eye care possible.

Under the new HIPPA (Health Insurance Portability and Accountability Act) laws, patients have certain rights related to your health information. You have the right to restrict the uses and disclosure of your information. You have the right to request that we only communicate with you privately. You have the right to read, review, and copy your information. If you would like a copy of the right to complain to our office or to the Secretary of Health and Human Services, or if you believe your privacy has been compromised by this office please express your request or concerns to us in writing.

Other than the procedures stated above, or where required by Federal, state, or local law, we will not disclose your health information without your written authorization. You may revoke that authorization in writing at any time.

### **Acknowledgement of Privacy Practices**

I acknowledge that I have read and understand the privacy practices of this office.

Signed \_\_\_\_\_ Date \_\_\_\_\_

## **Bellaire Family Eye Care Financial Policy**

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Payment is due at the time of service. For your convenience we accept VISA, Master Card, Discover, American Express or Debit Card.

**Using Insurance for Services @ Bellaire Family Eye Care Suite #107:** We have made prior arrangements with many insurers and other health plans. We will bill those plans with which we have an agreement and will collect any required co-payment at the time of service. In the event your health plan determines a service to be “not covered”, you will be responsible for the complete charge. In that event we will bill you, and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not have a prior agreement, payment is due at time of service. We will provide you with documentation for you to file.

**Minor Patients:** For all services provided to a minor, the adult accompanying the patient is responsible for payment.

**Services from our Vision Learning Center Suite #102:**

Our Vision Learning Center (Suite #102) is a Self Pay Clinic. We do not file any insurances and payment is due at the time of services.

**Missed Appointments:** In order to provide the best possible care and availability to all our patients, it is our policy to require 24 hour notice to cancel any appointment. At the time of cancellation you can reschedule a make-up date.

I have read and understand the financial policy of Bellaire Family Eye Care and the Vision Learning Center and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

\_\_\_\_\_  
Signature of Patient or Responsible Party if a Minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Co-Responsible Part

\_\_\_\_\_  
Name of Patient