Center for Vision Development

Patient Information

LAST Name:____________________________ DOB: ____/____/____

FIRST Name: ____________________________

Single: __ Married: __ Widowed: __ Divorced: __ Sex: M F

Address:____

City: __________________ ST: ________ Zip: __________

Student: __ Employed: __ Retired: __ Other: __

Employer Name:______________________ Occupation:________________

Race/Ethnicity

White: __
Black/African American __
Asian: __
American Indian/Alaska Native__
More than 1 Race: __
Native Hawaiian: __
Pacific Islander: __
Unreported/Refused to Report: __

Hispanic Latino: __
Non-Hispanic Latino: __
Unreported/Refused to Report: __

Guarantor

Self: __ Parent: __ Spouse: __ Other: __________ DOB: _____/_____/_____

LAST Name: ____________________________

FIRST Name: ____________________________ Sex: M F

Address: ____________________________

City: ____________ State: _____ Zip: __________

Home#: ____-____-______

Cell#: ____-____-________

Work#: ____-____-_______

Email:

____________@__________

Is it OK to leave a message? Y N

Preferred methods: Circle Two

Home Cell Work Email

Emergency Contact: Name:__________________________ Phone#: ______-______-_________

PRIMARY Insurance Co: ____________________ Policy#: ________________ Group#:______________
Policy Holder: Patient___ Guarantor above: ___
OTHER Relation: ____________>>> Last Name: _____________ First Name:____________ DOB_________

SECONDARY Insurance Co: ____________________ Policy#: ________________ Group#: ______________
Policy Holder: Patient___ Guarantor above___
OTHER Relation: ____________>>> Last Name: _____________ First Name: ____________ DOB_________

I was Referred by: Doctor:________________________ Phone#: ______-______-_________

WELCOME TO OUR PRACTICE

Our goal is to provide comprehensive vision care to our patients. Our philosophy is preventative and developmental in approach. To provide services in an efficient manner, please be aware of the following office policies:

*Fees for services are due at the time those services are rendered.
*A deposit is required on all materials when selected, and the balance is due upon delivery.
*A 1.5% service charge per month (18% per year) will be levied on all balances over 30 days old.
*We reserve the right to charge for missed appointments which are not canceled 24hrs in advance.
*A charge of $25, or the legal maximum, will be charged for any check not honored and or returned by your bank.
*If it is necessary to incur legal expenses to collect delinquent accounts, all expenses and court fees will be assumed by the debtor
*We will not file for coverage of any insurance in which we do not participate.
*Extended testing for contact lens fitting and certain vision problems may not be covered under your vision care plan. You will be billed separately for those services not covered.
*Patients are responsible for obtaining referrals, when necessary, from their physician prior to their appointment. If one is not supplied and your insurance does not pay you will be responsible for any charges.

I have read, understand, and agree to the above policies: ____________________________ Date:_________
(Signature of Responsible Party)

Center for Vision Development

Diagnostic and Rehabilitative Vision Care

Health History

Name: ______________________________ Age: __________________

Reason for today's visit:

____

____

Please fill out all information.

Inform our office when there are any changes in the medical information you provide below.

Eye and vision history:

When was your most recent eye/vision exam? ___/___/___ Dr. ____________________

Do you currently wear glasses or contacts? ____ All the time ____ Occasionally ____ No

Do you wear them for ____ Reading ____ TV ____ Computer work ____ Driving

Have you ever had eye surgery? Yes No When? __________ Condition ______________

Have you ever had the following eye conditions?

___ Sandy or Gritty feeling
___ Itching, Burning, Tearing
___ Discharge
___ Redness
___ Pain or soreness
___ Double Vision
___ Blurred Vision
___ Distorted Vision
___ Flashes of light
___ Increased Floaters
___ Shadows or Cobwebs
___ Loss of Sight
___ Loss of side vision
___ Foreign body sensation
___ Lazy eye/Crossed eye
___ Glaucoma/Cataracts
___ Frequent Infections
___ Dry eyes
___ Glare/Light sensitivity
___ Eye Strain
___ Frequent Styes

Use of Alcohol: ___ Never ___ Rarely ___ Moderate ___ Daily

Use of Tobacco: ___ Never ___ Daily: amount ______ ___ Former smoker ___years

Previous Hospitalizations/Surgeries/Serious illness Month/year

____ ____________________

____ ____________________

Family Medical History:

Age Medical/Eye Disease

Father __Glaucoma Cataract Macular degeneration Strabismus Amblyopia Diabetes Hypertension

Mother __ Glaucoma Cataract Macular degeneration Strabismus Amblyopia Diabetes Hypertension

Siblings__ Glaucoma Cataract Macular degeneration Strabismus Amblyopia Diabetes Hypertension

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Please list other conditions: Keratoconus Fuchs dystrophy Retinitis pigmentosa Color vision deficiency

____

____

Please indicate any personal history below: (current past)

Constitutional Symptoms
___ Good general health
___ Recent weight change
___ Fever
___ Fatigue

Hematologic/Lymphatic
___ Anemia
___ Bruising tendency
___ Slow to heal after cut
___ Phlebitis
___ Past transfusion
___ Enlarges glands

Cardiovascular
___ Heart disease
___ Chest pain
___ Palpitation
___ Swelling of feet, hands

Ears/Nose/Mouth/Throat
___ Earaches or drainage
___ Chronic sinus problems
___ Rhinitis
___ Nose bleeds
___ Mouth sores
___ Bleeding gums
___ Bad breath
___ Hearing loss or injury
___ Sore throat

Musculoskeletal
___ Joint pain
___ Arthritis
___ Muscle pains or cramps
___ Fibromyalgia
___ Back pain
___ Cold extremities
___ Difficulty walking

Allergic/Immunologic
___ Penicillin/Sulfa
___ Morphine/Narcotics
___ Novocain
___ Aspirin
___ Tetanus antitoxins
___ Iodine, Merthiolate
___ Animal fur/Dust/Mold
___ Pollen
___ Hay fever/Grass

Neurological
___ Numbness
___ Tingling sensation
___ Paralysis
___ Headaches
___ Light headed or dizzy
___ Head injury
___ Tremors
___ Seizures

Gastrointestinal
___ Loss of appetite
___ Bowel problems
___ Abdominal Pain
___ Frequent diarrhea
___ Nausea or Vomiting
___ Rectal bleeding
___ Eating disorder
___Ulcer

Other medical conditions:
___ High Blood Pressure
___ Cancer
___ Diabetes
____
____
____

Respiratory
___ Chronic/frequent coughs
___ Shortness of breath
___ Wheezing
___ Coughing up blood
___ Asthma

Psychiatric
___ Memory loss
___ Confusion
___ Insomnia
___ Nervousness
___ Dementia
___ Depression

Drugs/medications taken:
____
____
____
____
____

Patient (or guardian)
Signature: ______________________________ Date ____________

Dr. Marsha D. Benshir
Dr. Amber Smith
Center for Vision Development
Diagnostic and Rehabilitative Vision Care

Health and Developmental History

Child's Name____________________________Birth date______________Grade____________
Parent's Names___________________________Address__________________________________
Telephone(home)__________________________Parent's email___________________________

Prenatal History (During mother's pregnancy with this child):
Any unusual health or medical problems (Rh neg., measles, viral infection, toxemia, pre-eclampsia, etc.)
____
____

Any falls or other accidents ____
Any use of prescription or non-prescription drugs _____________________________________
Any use of alcohol or illegal drugs ____

Birth History:
Any difficulties with the delivery (anoxia, breach birth, etc.) ______________________________
____
Describe length of labor, help given to mother in form of drugs, or use of instruments _________
____
Child's condition at birth (incubator, jaundiced, breathing problems, etc.) ________________
____
Birth weight __________________ Full term or premature _________________________
Any special medical attention or hospitalization required during first month (i.e., oxygen, medications, etc.) ____

Developmental History:
At what age did your child do the following: Sat alone____ Crawled _____ Walked ________
Spoke first word _____Said sentences (combined two or more words) ____ Toilet trained____
Rode tricycle_____ Bicycle______ Started swimming_____ Throw and catch ball__________
Learned numbers______ Letters______ Colors______
Any activities or milestones accelerated or delayed (please list) ___________________________
____
Right or left handed _____ At what age was this noted _____________ Any concerns _______
____

How would you describe your child's temperament (happy, irritable, withdrawn, fears, etc.) ____
____
Any bed wetting or soiling (how often?) ____
Any feeding problems ____
Any concerns about speech ____
Any concerns about motor coordination ____
Age child entered preschool, if any _____ Any difficulties noted ___________________
Age child entered school ____ Any difficulties noted ______________________________
Special services provided (Remedial Reading/Chapter 1/Special Education/Speech). Please be specific ____
____
Was child retained, if so what grade/reason _______________________________________
Has child received any psychological evaluations or counseling through school or private sources
____

Health History:

Does child have a history of any of the following conditions: Respiratory _______
Cardiovascular _____ Gastrointestinal ______ Musculoskeletal _____ Neurological ______
Allergies ______ Hearing (ear infections) ______ Vision _____ Other __________
Note any serious illness, surgery, or unusual conditions ___________________________
____

If high fever accompanied illness, to what degree and duration _____________________
___________ Any convulsions ____
Note any accidents or head injuries ____
Was child ever unconscious ________________ How long ________________________
Has child ever been referred to a specialist or been seen by an outside clinic _____________
____
If so, please specify date and result ____
____

Present Health:

Does child have any of the following symptoms more frequently than most children (check all that apply) Indigestion ___ Constipation ___ Diarrhea ___ Vomiting ___ Fever ___
Dizzy spells ___ Restlesness ___ Inattention ___ Headaches ___ (when and how often) ______
Starring spells ___ Aches and pains ___ Difficulty sleeping ___
Difficult eating/picky eater ______
Other health conditions ____
Any medications (please note dosage) ____
Date of last physical examination ______________ Physician's name __________________

Family History:

Please check any family history of these conditions among parents, siblings, grandparents, etc.:
Vision problems ___ Hearing problems ___ Speech problems ___ Reading problems ___
Learning disabilities ___ Special education ___ Attention problems ___ Hyperactivity ___
Seizure disorders ___ Legal problems ___ Emotional problems (depression, anxiety, etc.) _____
Left-handedness ___ Alcohol/Drug abuse ___ Behavior problems ____
Present health of family members ______________________________

____

Environment:

If both parents work outside the home, who is caretaker ______________________________
How many hours per day is child with caretaker ______________________________
Is second language spoken in the home ______ Language ______________________________
Child's relationship with family members ______________________________

____

Child's relationship with friends, neighbors ______________________________

____

Activities or types of play in which the child participates (sports, clubs, etc.) ______________

____

Any recent family stressors ______________________________

____

Has child experienced any prenatal separations. Divorces, or death, and if so, is this ongoing ___

____

Any history of abuse or neglect ______________________________

____

How does the child handle self-care responsibilities in the home ______________________________

____

How much time does your child spend watching television, videos, or playing video games ____

____

Does anyone in the home smoke ______________ Any pets ______________________________

Date completed ____________ **Name of person completing form** ______________________

Signature ______________________________

Thank you for completing this form. Please list below any additional considerations or concerns.

____

____

____

____

____

Center for Vision Development

Lifestyle Checklist

Name: ______________________________ Date:__________ ___PRE/___POST

Please assign a value between 0 and 4 for each symptom.

0= never or non-existent / 1= seldom / 2= occasionally / 3=frequently / 4= always

1	Blurred vision at near	
2	Double vision	
3	Headaches associated with near work	
4	Words run together when reading	
5	Burning, stinging, watery eyes	
6	Falling asleep when reading	
7	Vision worse at the end of the day	
8	Skipping or repeating lines when reading	
9	Dizziness or nausea associated with near work	
10	Head tilt or closing one eye when reading	
11	Difficulty copying from the chalkboard	
12	Avoidance of reading and near work	
13	Omitting small words when reading	
14	Writing uphill or downhill	
15	Misaligning digits in columns of numbers	
16	Reading comprehension declining over time	
17	Inconsistent/poor sports performance	
18	Holding reading material too close	
19	Short attention span	
20	Difficulty completing assignments in reasonable time	
21	Saying "I can't" before trying	
22	Avoiding sports and games	
23	Difficulty with hand tools-scissors, calculator, keys, etc.	
24	Inability to estimate distances accurately	
25	Tendency to knock things over on desk or table	
26	Difficulty with time management	
27	Difficulty with money concepts, making change	
28	Misplaces or loses papers, objects, belongings	
29	Car sickness/motion sickness	
30	Forgetful, poor memory	

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Statement of Office Policies-Privacy Notice

This practice is in compliance with HIPAA regulations. Your records are strictly confidential and will not be released for any purpose not specified as related to your care. We do not provide patient lists to any third parties.

With the new changes in health care regulations, we can no longer release copies of records or reports without a signed, written request from the patient, parent, or legal guardian. This includes release of prescription information to any third party.

We will not give prescription information over the phone for any purpose. When any prescription is to be filled outside of our office, the patient will be given a written prescription. Prescriptions may be faxed to a pharmacy or optician with the patient's written permission.

Your insurance plan may not cover all services we provide. If special testing is recommended, you will be responsible for that part of the bill that is not covered by your major medical. This will be billed to you separately.

Reports to other professionals or schools are rarely covered by insurance. The cost of a written reports is not included in the cost of the services. This will be billed separately, and payment is the responsibility of the patient. The exception to this is a report to a referring doctor.

A statement explaining your rights and responsibilities under HIPAA is available in our office. You are welcome to read this at any time. If you would like a copy of our complete HIPAA policy, it will be provided upon request.

This practice is required by Federal law to maintain the privacy of your protected health information (PHI), and to provide you with this Privacy Notice detailing our Practice's legal duties and privacy practices with respect to your PHI.

Under the Privacy Rule, our practice may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under Federal law.

This practice is required to abide by the terms of this Privacy Notice. This practice reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains. This practice will distribute any revised Privacy Notice to you prior to implementation.

This practice will not retaliate against you filling a complaint. This notice is in effect as of April 15, 2003.

By signing my name below, I acknowledge receipt of a copy or this Privacy Notice, and I understand and agree to its terms.

_________________________ _________________________

Patient/Parent/Guardian *Date*