Patient's Name:_____ Birthdate:_____

Parent/Gaurdian Name:_____ Birthdate:_____

Address:_____
_____

Email Address:_____
Contact number:
Home: _____
Work: _____
Cell: _____

FINANCIAL AUTHORIZATION:

I authorize and request my insurance company to pay directly to Suburban Eye Care, P.C.
I understand that my insurance carrier may pay less than the billed services and materials. I agree to be responsible for the payment of all services and materials rendered on my behalf or my dependents. Any portion not paid by the insurance company will be the patient's responsibility. A 1 ½% finance charge will be applied to any amount over 30 days.

_____ _____
Patient/ Guardian Signature Date

HIPAA PRIVACY POLICY:

I have received or was offered and declined a notice of Suburban Eye Care, P.C. privacy laws HIPAA.

_____ _____
Patient/ Guardian Signature Date

Name_____ Date_____

Date of child's last eye examination_____ Has child ever had vision therapy? ❑ Yes ❑ No

Has Child ever worn glasses? ❑ Yes ❑ No Does he/she wear glasses now? ❑ Yes ❑ No
If yes: ❑ for distance only ❑ for near only ❑ wears them full time

Does child wear contact lenses? ❑ Yes ❑No Any problems?_____

This is your opportunity to tell us about all areas of concern about your child's vision.

What is your main reason for coming here today?_____

_____

Have you noticed any unusual signs or symptoms that concern you?_____

_____

Has your child's ability to do any activity been restricted because of vision?

Please explain_____

HEALTH HISTORY: Check any conditions that apply to your child or that run in your family.

Allergies	❑ Child	❑ Family	Lazy eye	❑ Child	❑ Family
Respiratory disease	❑ Child	❑ Family	Turned eye	❑ Child	❑ Family
Cancer	❑ Child	❑ Family	Color "blind"	❑ Child	❑ Family
Diabetes	❑ Child	❑ Family	Light sensitive	❑ Child	❑ Family
Drug sensitive	❑ Child	❑ Family	Eyestrain	❑ Child	❑ Family
Heart problem	❑ Child	❑ Family	Dry eyes	❑ Child	❑ Family
High blood pressure	❑ Child	❑ Family	Floaters/spots	❑ Child	❑ Family
Thyroid	❑ Child	❑ Family	Flashing lights	❑ Child	❑ Family
Migraine or headaches	❑ Child	❑ Family	Retinal detachment	❑ Child	❑ Family
Blindness	❑ Child	❑ Family	Cataracts	❑ Child	❑ Family
Head trauma	❑ Child		Glaucoma	❑ Child	❑ Family
			Macular Degeneration	❑ Self	❑ Family
			Eye surgery or injury	_____	

Is your child currently under a physician's care? ❑ Yes ❑ No Why?_____

Is your child regularly taking pills or medications? ❑ Yes ❑ No Specify _____

Date of child's last physical_____ How is child's general health?_____

Developmental Milestones

Full Term Pregnancy? ❑ Yes ❑ No Normal Birth? ❑ Yes ❑ No

Any complications before, during or immediately following delivery? ❑ Yes ❑ No

Please describe_____

Did your child creep (stomach on floor)? ❑ Yes ❑ No at what age?_____

Did your child crawl (stomach off floor)? ❑ Yes ❑ No at what age?_____

Did your child move around on all fours? ❑ Yes ❑ No at what age?_____

At what age did your child walk? _____ Was your child active? ❑ Yes ❑ No

Speech: First words at age_____ Was early speech clear to others? ❑ Yes ❑ No
Is child's speech clear now? ❑ Yes ❑ No

School-Related Vision Problems: Questions for parents:

Have any of your children had difficulty in school? ❑ **Yes** ❑ **No**

Please describe

_____

How do you feel your child is doing in school? ❑ **Well** ❑ **Below potential** ❑ **Poorly**

Please check the signs and symptoms that best describe how your child is doing in school

- ❑ Does your child squint when looking up from reading?
- ❑ Have trouble seeing the chalkboard?
- ❑ Frequently blink or rub eyes?
- ❑ Have headaches after doing school work?
- ❑ Frequently awkward, bump into things, knock things over?
- ❑ Hold books extremely close?
- ❑ Read a great deal of the time?
- ❑ Report that things look blurry?
- ❑ Have trouble copying work from the chalkboard to paper?

- ❑ Spend a long time doing homework that should take only a few minutes?
- ❑ Reduced attention span, can concentrate for only a moderate time?
- ❑ Covers one eye by leaning on hand?
- ❑ Lays head on desk when doing pencil work?
- ❑ Frequently loses place when reading?
- ❑ Skips or re-reads words and lines?
- ❑ Reverses words or letters (was for saw, b for d) beyond second grade?
- ❑ Does better at math than English, history or social studies?
- ❑ Must re-read material several times to grasp its meaning?
- ❑ Gets tired quickly when doing reading or homework?

- ❑ Short attention span? Can concentrate on reading work for only a few minutes.
- ❑ Daydreams a lot? Stares off into the distance frequently?
- ❑ Learns best through auditory tactics (listens to learn)?
- ❑ Misbehavior has become a problem (to cover up poor school performance)?
  - ❑ Acts up when asked to do school work
  - ❑ Class clown, "goofs off"
  - ❑ Moody or depressed about school and life
  - ❑ Aggressive, hits or dominates other children
- ❑ Avoids work that includes reading or near seeing?
- ❑ Is more than 1 year behind group in reading-related skills?
- ❑ Has poor posture? Slouches, slumps in chair?

How does your child react to fatigue? ❑ Becomes Irritable ❑ Becomes Excited

Other Reaction_____

How does your child react to tension? ❑ Turn inward ❑ Anxiety (nail biting) ❑Anger

Other Reaction_____

RECREATION AND LEISURE: In what recreational activities does your child participate? (Circle)
Read, baseball, basketball, soccer, swim, build models, sew, dance, perform, play an instrument.

Other recreational or sports activities?_____

Does your child wear protective eyewear for his/her sport? ❑**Yes** ❑**No**

Does your child watch much television? ❑ **Yes** ❑ **No** Number of hours daily_____

Does your child use a computer at home? ❑ **Yes** ❑ **No** Number of hours daily_____

Does your child use a computer at school? ❑ **Yes** ❑ **No** Number of hours daily_____

Does child often play video games? ❑ **Yes** ❑ **No** Number of hours daily_____

Does he/she play hand-held video games? ❑ **Yes** ❑ **No** Screen type ❑ Bright ❑ Dim