PEDIATRIC EYE MD

Welcome!

Patient's Name:
Today's Date:

Our mission is to provide outstanding care in a safe, pleasant and efficient setting. We respect your time and the privilege of participating in your health care. These are our office policies:

1. If you make an appointment with us and do not show up for the visit or call more than 24 hours in advance to cancel/reschedule the visit, then you will be charged **$50** for the administrative cost of making the appointment. **You will not be rescheduled/seen before this is paid. THIS IS NOT COVERED BY INSURANCE**.

I understand and consent to this policy. x _____ Date:

2. I, _____(please print your name), assign insurance payment to be made to PediatricEyeMD for services rendered to The Patient .

a. If the insurance plan that covers The Patient requires that I obtain a **referral** from his/her primary care doctor (pediatrician, internist, or family practitioner), then **it is my responsibility** to obtain this referral. If I do not have a referral and I pay for the visit, I will be refunded for the visit **only** if I bring in a valid referral.

b. I understand that I am responsible for non-covered services, co-payments, unmet deductibles, co-insurance fees. In the event that my insurance company reclaims monies at any time for a visit because I was not eligible or had other insurance, I am responsible for the billed amount.

c. If I default on the above responsibilities, I understand that I will be held responsible for *any and all* costs associated with collecting my debt, including court costs, collection fees and a **$200** administration fee if a court action is commenced.

I understand and consent to this policy. x _____ Date:

3. **Important Insurance Information (so we can bill properly)**

Is this insurance policy held in the name of the patient being seen? Yes/No

IF NO, then what is the **name** of the **insurance policy holder**? _____

What is the **birthdate** of the **policy holder**? _____

What is the **social security number** of the **policy holder**? _____-_____-_____

Consent for ePrescribing

Our practice uses ePrescribing software. This allows us to send your prescriptions over the internet to your pharmacy. It also lets us see information such as drug interactions and your prescription history. The benefit to you:

- Less confusion over handwritten prescriptions or unclear phone calls
- Reduced possibility of medical errors and less chance of adverse drug reactions
- No need to drop off a prescription at the pharmacy

I agree that PediatricEyeMD may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. This consent will remain in effect for 24 months unless I revoke it.

Signature_x_____ Date:

HIPAA Acknowledgement

I, the parent/guardian of The Patient , have received a copy of PediatricEyeMD's notice of privacy practices.

Signed: _x_____ Date:

□ Refused to sign □ Reason for refusal:

PEDIATRIC EYE MD

New Patient Demographics

Name: **Date of Birth:**

Date:

Patient's Address: Patient's Phone: Work phone: Primary insurance company:

Patient is □ living with both parents □ living with mother only □ living with father only □ living with relative, guardian, or foster parent(s)

Full name of Parent (or Guardian) Occupation: Daytime phone:	Full name of Parent (or Guardian) Occupation: Daytime phone:

Other phone numbers where we might reach parents:

Names and ages of brothers and sisters:

How did you learn about our practice?

Who is the referring pediatrician/primary care doctor?

What is this the doctor's phone number?

Are there any other doctors to whom we should send a report?

Please answer the questions on the next page

PEDIATRIC EYE MD

The Patient

New Patient History and Review of Systems

History of THE PATIENT 's Eye Problems: □ *None of the things in this section*

Eye injuries:	Yes/No
Glasses:	Yes/No
Patching :	Yes? (which eye? starting at what age? until when?...)
Eye surgeries:	Yes/No

Blurred vision
Can't make normal eye contact
Clumsiness/bumping into things
Crossed or wandering eye
Double vision
Excessive eye rubbing
Excessive squinting
Frequent tearing or discharge
Light sensitivity
Tired eyes when reading

Other:

Social History:

Are both parents alive? In good health?
Has there been a recent change in The Patient 's academic performance related to his/her vision?
How about his/her sports performance?

Review of Systems for THE PATIENT : □ *None of the things in this section*

Arthritis/joint problems
Fever or weight loss
Frequent ear infections
Heart problems
Kidney or urinary disease
Other ear, nose, or throat problems
Lung disease
Mental illness
Neurologic problems
Sickle cell disease or trait
Skin problems

Other:

The Patient has: □ no known drug allergies (NKDA) □ allergies to the following medications:

Please list ANY and ALL surgeries, hospitalizations, major illnesses, and injuries:

Please list ANY and ALL medications that The Patient is currently taking, INCLUDING EYE DROPS:

Family History – as pertains to "blood" relatives □ *None of the things in this section*

Blindness at an early age
Cataracts in childhood
Eye muscle surgery
Glaucoma in childhood
Other types of serious eye disease
Patching treatment
Strabismus ("crossed eye")
Complications from anesthesia
Genetic diseases

Birth History:

Birth weight _____lb, _____oz
Born at how many weeks into the pregnancy?
Problems during pregnancy?
Problems during delivery?

Thank you for your time!