Pediatric Ophthalmology, P.A. and the Center for Adult Strabismus—Minor

8222 Douglas Ave. #400 Dallas, Tx 214-369-6434 1631 Lancaster Dr. #200 Grapevine, Tx 817-329-5433
6130 W Parker Rd. #508 Plano, Tx 972-981-8430

MINOR PATIENT REGISTRATION

PATIENT NAME _____ Male ☐ 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

☐ MARRIED ☐ SEPARATED ☐ DIVORCED

PARENT'S NAME _____
SS # _____ DOB _____
ADDRESS _____
_____
HOME PHONE _____
EMPLOYER _____
WORK PHONE _____
CELL PHONE _____
E-Mail Address _____

PARENT'S NAME _____
SS#: _____ DOB _____
ADDRESS _____
_____
HOME PHONE _____
EMPLOYER_____
WORK PHONE _____
CELL PHONE _____
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.

_____ _____
Signature Parent/Legal Guardian Date

Adult Strabismus and Pediatric Ophthalmology - New Patient Questionnaire

REASON FOR VISIT: (Important, please complete)

Patient History (biological ☐, adopted ☐)

History of Eye Problems:

Yes	No		
☐	☐	Glasses	How old is current pair? _____
☐	☐	Contact Lens	How old is current pair? _____
☐	☐	Prisms	How long? _____

Yes	No	Past Ocular History	Age	Yes	No	Past Ocular History	Age
☐	☐	Eye exam by specialist	_____	☐	☐	Other eye surgery	_____
☐	☐	Amblyopia	_____	☐	☐	Eye injury	_____
☐	☐	Patching or dilating drops	_____	☐	☐	Recurring “pink eye	_____
☐	☐	Eye exercises	_____	☐	☐	Cataract	_____
☐	☐	Misaligned eye	_____	☐	☐	Glaucoma	_____
☐	☐	Eye muscle surgery	_____	☐	☐	Diabetic eye disease	_____

Diagnosed eye diseases not mentioned above:_____

Medical History

Yes	No	Condition	Yes	No	Condition
☐	☐	Frequent ear infections	☐	☐	Diabetes
☐	☐	Sinus disease	☐	☐	Anemia
☐	☐	Heart disease	☐	☐	Kidney disease
☐	☐	High blood pressure	☐	☐	Neurologic disease
☐	☐	Asthma	☐	☐	Seizures or stroke
☐	☐	Allergies	☐	☐	Depression
☐	☐	Arthritis	☐	☐	Cancer
☐	☐	Thyroid problem	☐	☐	Other illness not mentioned

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: ☐ None

(continued)

Birth History (Pediatric patients only) **Birth weight:** _____ **lbs** _____ **oz**

Yes	No	Condition	Please provide details
☐	☐	Problems in pregnancy	Describe: _____
☐	☐	Problems in delivery	Describe: _____
☐	☐	Forceps delivery	Describe: _____
☐	☐	Caesarean section	
☐	☐	Delivered early	
☐	☐	Delivered late	
☐	☐	Baby kept in hospital due to illness	Why and how long? _____
☐	☐	Delay in sitting, walking, talking or development	Describe: _____
☐	☐	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?				
☐	☐	Glasses before age 6	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Other
☐	☐	Amblyopia ("lazy eye")	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Other
☐	☐	Patching treatment	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Other
☐	☐	Strabismus (crossed or wandering eye)	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Other
☐	☐	Eye muscle surgery	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Other
☐	☐	Cataracts	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Other
☐	☐	Glaucoma	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Other
☐	☐	Blindness	☐ Father	☐ Mother	☐ Sister	☐ Brother	☐ Other
		Other serious eye disease (describe) _____					

Received by:	Date: