

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

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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 _____	PARENT'S NAME _____
SS # _____ DOB _____	SS#: _____ DOB _____
ADDRESS _____	ADDRESS _____
_____	_____
HOME PHONE _____	HOME PHONE _____
EMPLOYER _____	EMPLOYER _____
WORK PHONE _____	WORK PHONE _____
CELL PHONE _____	CELL PHONE _____
E-Mail Address _____	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		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			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:	<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 100px; height: 20px;"></td> <td style="padding: 2px;">None</td> </tr> </table>		None
	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: