



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

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6000 W. Spring Creek Pkwy., Suite 130
Plano, TX 75024
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MINOR PATIENT REGISTRATION

Patient Name _____ Date of Birth ____/____/____ Male ____ Female ____
Street _____ City _____ State ____ Zip _____
Primary Phone _____ Home Cell 2nd Phone _____ Home Cell
Pediatric Physician _____ Phone _____
Referring Physician _____ Phone _____

Parents/Legal Guardians

PLEASE COMPLETE FOR *BOTH* PARENTS

Married Separated Divorced Other

Parents Name _____ Parents Name _____
DOB _____ DOB _____
Address _____ Address _____
Cell Phone _____ Cell Phone _____
Employer _____ Employer _____
Work Phone _____ Work Phone _____
Home Phone _____ Home Phone _____
Email _____ Email _____

Insurance Information

PRIMARY INSURANCE

Insurance Name: _____
Member ID: _____
Group Number: _____
Member Name: _____
Subscriber DOB: _____
Relationship to Patient: _____

SECONDARY INSURANCE

Insurance Name: _____
Member ID: _____
Group Number: _____
Member Name: _____
Subscriber DOB: _____
Relationship to Patient: _____

My preferred method of communication: Text Email Phone
If preferred communication is phone, please check one: Leave a message with detailed information
 Leave a message with call back number only

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 Patient/Legal Guardian Date

Authorization

I hereby give my consent to the physicians and other clinical personnel of Pediatric Ophthalmology for my evaluation and treatment 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 the time of service.

Signature Patient/Legal Guardian Date

Patient Name: _____ Account # _____ Guarantor / Guardian Name: _____

CONSENT for COMMUNICATION via E-MAIL and TEXT MESSAGE

I, _____, hereby consent to have the staff of Pediatric Ophthalmology, PA (POPA), which may include reimbursement and billing staff and technicians involved in my care communicate with me and my physicians, where appropriate, via e-mailing or text messaging regarding the following aspects of my medical care and treatment: test results, prescriptions, appointment, billing, etc. I understand that e-mail and/or text message is not a confidential method of communication and may have the following risks:

- Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Senders can easily misaddress an email or text and send the information to an undesired recipient.
- Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
- Your employers and/or on-line services may have a right to inspect emails and texts sent through their systems.
- Emails and texts can be intercepted, altered, forwarded or used without authorization or detection or errors can occur in the transmission.
- Emails and texts can be used as evidence in court.
- Emails and texts may not be a reliable means of communication.
- Email and text messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.

I further understand that there is a risk that e-mail or text message communication between my physician and me or members of my physician’s office staff, or between my physician and other physicians regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I understand that in an urgent or emergent situation I should call my providers or go to the Emergency Room and not rely on e-mail or text message. I agree not to disclose sensitive medical information such as information related to HIV, Mental health or substance abuse. I understand and acknowledge that POPA cannot guarantee the privacy, security or confidentiality of information transmitted via email or text. I understand that I may revoke my consent at anytime by advising POPA in writing.

Email Address: _____ Cell Phone Number for Text Messages: _____

Signature

Date

AUTHORIZATION FOR EXAMINATION (MINORS)

Unless a court has stated otherwise (and a formal legal document can be provided to us), the parents listed on the birth certificate are the only people allowed to approve medical care being provided to a child. If a parent or LEGAL guardian isn’t bringing the child to his/her appointment, then we need permission from the parent that we can see that child. Please complete the following Information to authorize us to see your child with the following people you would like to be able to bring your child to appointments.

I, the parent/guardian, give the physicians and clinical staff permission to examine, instill drops and administer necessary tests to the following patient(s) without my presence. I swear that the information below is correct, and that I am the parent/legal guardian of the below-mentioned patients.

I AUTHORIZE the following people to bring my child(ren) to see the doctors of Pediatric Ophthalmology, PA:

NAME: _____ RELATIONSHIP (TO CHILD) _____ DOB: _____

NAME: _____ RELATIONSHIP (TO CHILD) _____ DOB: _____

My following child(ren) are allowed to be escorted to his/her appointments by the above-mentioned people:

PATIENT’S NAME: _____ DOB: _____ PATIENT’S NAME: _____ DOB: _____

PATIENT’S NAME: _____ DOB: _____ PATIENT’S NAME: _____ DOB: _____

PARENT/GUARDIAN NAME: _____ SIGNATURE: _____

DAY-TIME PHONE NUMBER: _____ ALTERNATE PHONE NUMBER: _____

CONTACT INFORMATION OF ANOTHER PARENT/LEGAL GUARDIAN IF I’M UNABLE TO BE REACHED DURING THE PATIENT’S EXAM

NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____ ALTERNATE PHONE NUMBER: _____

Patient Name: _____ Account # _____ Guarantor / Guardian Name: _____

Strabismus and Pediatric Ophthalmology - New Patient Questionnaire

REASON FOR VISIT (Important, please complete)

Patient History (biological _____, adopted _____)

History of Eye Problems:

Yes No

- | | | | |
|--------------------------|--------------------------|--------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Glasses | How old is current pair? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Contact Lens | How old is current pair? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Prisms | How long? _____ |

Yes	No	Past Ocular History	Age	Yes	No	Past Ocular History	Age
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- | | | | | | | | |
|--------------------------|--------------------------|----------------------------|-------|--------------------------|--------------------------|----------------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | Eye exam by specialist | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Other eye surgery | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Amblyopia | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Eye injury | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Patching or dilating drops | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Recurring "pink eye" | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye exercises | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Cataract | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Misaligned eye | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye muscle surgery | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Diabetic eye disease | _____ |

Diagnosed eye diseases not mentioned above: _____

Medical History

Yes	No	Condition	Yes	No	Condition
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- | | | | | | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent ear infections | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus disease | <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Neurologic disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Seizures or stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies | <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problem | <input type="checkbox"/> | <input type="checkbox"/> | Other illness not mentioned |
| <input type="checkbox"/> | <input type="checkbox"/> | 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

Birth History (Pediatric patients only)

Birth weight: _____ lbs _____ oz

Yes	No	Condition	Please provide details
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- | | | | |
|--------------------------|--------------------------|---|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Problems in pregnancy | Describe: |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems in delivery | Describe: |
| <input type="checkbox"/> | <input type="checkbox"/> | Forceps delivery | Describe: |
| <input type="checkbox"/> | <input type="checkbox"/> | Caesarean section | |
| <input type="checkbox"/> | <input type="checkbox"/> | Delivered early | |
| <input type="checkbox"/> | <input type="checkbox"/> | Delivered late | |
| <input type="checkbox"/> | <input type="checkbox"/> | Baby kept in hospital due to illness | Why and how long? |
| <input type="checkbox"/> | <input type="checkbox"/> | Delay in sitting, walking, talking or development | Describe: |
| <input type="checkbox"/> | <input type="checkbox"/> | Any outstanding school difficulties? | Describe: |

Family History

Sibling names _____

Names of siblings seen at this practice _____

Yes	No	Eye conditions in other family member	Which relative? (check one)
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- | | | | |
|--------------------------|--------------------------|--|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Glasses before age 6 | <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Other |
| <input type="checkbox"/> | <input type="checkbox"/> | Amblyopia ("lazy eye") | <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Other |
| <input type="checkbox"/> | <input type="checkbox"/> | Patching treatment | <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Other |
| <input type="checkbox"/> | <input type="checkbox"/> | Strabismus (crossed or wandering eye) | <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Other |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye muscle surgery | <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Other |
| <input type="checkbox"/> | <input type="checkbox"/> | Cataracts | <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Other |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Other |
| <input type="checkbox"/> | <input type="checkbox"/> | Blindness | <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Other |
| <input type="checkbox"/> | <input type="checkbox"/> | Other serious eye disease (describe) _____ | <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Other |

Received by: _____ Date: _____