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

Dallas Office
7150 Greenville Ave., Suite 305
Dallas, TX 75231
214-369-6434

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1631 Lancaster Dr., Suite 200
Grapevine, TX 76051
817-329-5433

Plano Office
6000 W. Spring Creek Pkwy., Suite 130
Plano, TX 75024
972-797-1200

ADULT PATIENT REGISTRATION

Patient Name_____ Date of Birth____/____/_____ Male_____ Female _____
Street _____ City_____ State_____ Zip_____
Primary Phone_____ □ Home □ Cell 2nd Phone_____ □ Home □ Cell
Employer_____
Address _____
Work Phone_____ Email _____
Referring Physician_____ Primary Physician _____
First Name Last Name First Name Last Name

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 #: _____

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

APPROVED HIPAA CONTACTS

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account and Medical Conditions to the patient or legal guardian.**

If you would like to add additional contacts to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person listed. In addition, please chose the person you would like to list as your **Emergency Contact** in the event an emergency situation was to take place at our office.

_____ _____ _____ □ Billing Information
□ Medical Condition
□ Emergency Contact

Contact Name Relationship to Patient Contact Phone Number

_____ _____ _____ □ Billing Information
□ Medical Condition
□ Emergency Contact

Contact Name Relationship to Patient Contact Phone Number

_____ _____

Signature Date

PATIENT NAME _____ ACCOUNT # _____ DATE _____

IF YOU WEAR EYEGLASSES, HOW OLD WERE YOU WHEN YOU STARTED WEARING THEM?_____ HOW OLD IS THE PRESCRIPTION? ____

IF YOU WEAR CONTACTS, HOW OLD IS THE PRESCRIPTION?_____ HOW MANY HOURS PER DAY DO YOU WEAR THEM?_____

IF YOU HAVE BEEN TOLD TO DO EYE EXERCISES, DESCRIBE THE EXERCISES _____

_____

_____

_____

WHAT IS THE DATE OF YOUR LAST DILATED EYE EXAM?_____ WHO DID THE EXAM? _____

REVIEW OF SYSTEMS - PLEASE CHECK EITHER YES OR NO • DO NOT LEAVE ANY UNANSWERED

HAVE YOU RECENTLY HAD: A FEVER ☐ YES ☐ NO UNINTENTIONAL WEIGHT LOSS ☐ YES ☐ NO

DO YOU? SMOKE ☐ YES ☐ NO USE RECREATIONAL DRUGS ☐ YES ☐ NO ABUSE ALCOHOL ☐ YES ☐ NO

ARE YOU HAVING ANY OF THE FOLLOWING DIFFICULTIES:

YES NO IF YOU ANSWER YES TO THE FOLLOWING SEVEN QUESTIONS, DESCRIBE THE SYMPTOMS/ISSUES YOU'VE HAD WITH THESE ISSUES

☐ ☐ DOUBLE VISION: IF YES, WHEN DID IT BEGIN:_____

IF YOU GET DOUBLE-VISION,

☐ YOU NOTICE IT WHEN LOOKING AT FAR DISTANCES (DRIVING, WATCHING TV, PLAYING SPORTS, ETC.)

☐ YOU NOTICE IT WHEN LOOKING AT NEAR RANGES (READING, USING COMPUTER, DOING FINE HANDWORK LIKE KNITTING, ETC.)

☐ YOU NOTICE WHEN LOOKING A FAR AND NEAR RANGES

☐ YOU CLOSE YOUR EYE FOR COMFORT. IF SO, WHICH EYE ☐ RIGHT ☐ LEFT

IF YOU GET DOUBLE VISION, DO YOU FEEL THAT IT'S (CHOOSE ONE): ☐ IMPROVING ☐ WORSENING ☐ NO CHANGE

IF YOU GET DOUBLE VISION, DO YOU HAVE PRISM(S) IN YOUR GLASSES ☐ YES ☐ NO

YES NO

☐ ☐ DISTORTED VISION: IF YES, WHICH EYE. ☐ RIGHT ☐ LEFT

☐ ☐ EYE STRAIN

☐ ☐ MISALIGNED EYES BUT NOT DOUBLE VISION

☐ ☐ EYE MISALIGNMENT IN CHILDHOOD

☐ ☐ PREVIOUS EYE MUSCLE SURGERY. IF YES, PLEASE BE CERTAIN TO DOCUMENT SURGERY IN PREVIOUS EYE SURGERY AREA BELOW

YES	NO	*HAVE YOU EVER BEEN TOLD YOU HAVE?*
☐	☐	LAZY EYE/AMBLYOPIA (SINCE CHILDHOOD)
☐	☐	CORNEAL DISEASE
☐	☐	DIABETIC EYE DISEASE
☐	☐	GLAUCOMA
☐	☐	RETINAL DETACHMENT/DISEASE
☐	☐	OTHER_____

YES	NO	*DOES/DID ANY BLOOD FAMILY MEMBER HAVE?*
☐	☐	LAZY EYE/AMBLYOPIA (SINCE CHILDHOOD)
☐	☐	CORNEAL DISEASE
☐	☐	DIABETIC EYE DISEASE
☐	☐	GLAUCOMA
☐	☐	RETINAL DETACHMENT/DISEASE
☐	☐	OTHER_____

HAVE YOU PREVIOUSLY HAD CATARACT SURGERY OR ANY EYE SURGERIES OR INJURIES (WHAT, WHEN) _____

_____

_____

_____

		HAVE YOU EVER BEEN TOLD YOU HAVE?				*DOES OR DID ANY BLOOD FAMILY MEMBER HAVE?*	
YES	NO		YES	NO		YES	NO
☐	☐	CANCER	☐	☐	KIDNEY DISEASE	☐	☐ CANCER
☐	☐	DIABETES-ADULT ONSET	☐	☐	LUNG BREATHING DISEASE	☐	☐ DIABETES-ADULT ONSET
☐	☐	DIABETES-CHILDHOOD ONSET	☐	☐	LUPUS OR MULTIPLE SCLEROSIS	☐	☐ DIABETES-CHILDHOOD ONSET
☐	☐	GRAVES/THYROID DISEASE	☐	☐	PSYCHIATRIC DISORDER	☐	☐ GRAVES/THYROID DISEASE
☐	☐	HEART DISEASE	☐	☐	PARKINSON'S DISEASE	☐	☐ HEART DISEASE
☐	☐	HIGH BLOOD PRESSURE	☐	☐	RENAL FAILURE	☐	☐ HIGH BLOOD PRESSURE
☐	☐	HIV/AIDS	☐	☐	RHEUMATOID ARTHRITIS	☐	☐ LUPUS OR MULTIPLE SCLEROSIS
☐	☐	PROBLEMS WITH ANESTHESIA	☐	☐	SKIN DISEASE	☐	☐ PARKINSON'S DISEASE
☐	☐	MALIGNANT HYPERTHERMIA	☐	☐	SLEEP APNEA AND USE OF CPAP		
☐	☐	TO TAKE ANTIBIOTICS PRIOR TO DENTAL WORK OR SURGERY?				☐	☐ OTHER_____

WHAT IS YOUR HEIGHT:_____ WHAT IS YOUR APPROXIMATE WEIGHT: _____

OTHER_____

HAVE YOU HAD ANY HEALTH-RELATED SURGERIES OR INJURIES (WHAT, WHEN) _____

_____

_____

_____

PATIENT:______________________________ Account #____________________

CURRENT MEDICATIONS

Medication Name; Dosage & use (if known)	Reason Taking Med	FOR STAFF USE (Date & Initial)	(Date & Initial)
		☐ Reviewed - Added ☐ Reviewed - D/C	☐ Reviewed - Added ☐ Reviewed - D/C
		☐ Reviewed - Added ☐ Reviewed - D/C	☐ Reviewed - Added ☐ Reviewed - D/C
		☐ Reviewed - Added ☐ Reviewed - D/C	☐ Reviewed - Added ☐ Reviewed - D/C
		☐ Reviewed - Added ☐ Reviewed - D/C	☐ Reviewed - Added ☐ Reviewed - D/C
		☐ Reviewed - Added ☐ Reviewed - D/C	☐ Reviewed - Added ☐ Reviewed - D/C
		☐ Reviewed - Added ☐ Reviewed - D/C	☐ Reviewed - Added ☐ Reviewed - D/C
		☐ Reviewed - Added ☐ Reviewed - D/C	☐ Reviewed - Added ☐ Reviewed - D/C
		☐ Reviewed - Added ☐ Reviewed - D/C	☐ Reviewed - Added ☐ Reviewed - D/C
		☐ Reviewed - Added ☐ Reviewed - D/C	☐ Reviewed - Added ☐ Reviewed - D/C
		☐ Reviewed - Added ☐ Reviewed - D/C	☐ Reviewed - Added ☐ Reviewed - D/C
		☐ Reviewed - Added ☐ Reviewed - D/C	☐ Reviewed - Added ☐ Reviewed - D/C
		☐ Reviewed - Added ☐ Reviewed - D/C	☐ Reviewed - Added ☐ Reviewed - D/C
		☐ Reviewed - Added ☐ Reviewed - D/C	☐ Reviewed - Added ☐ Reviewed - D/C
		☐ Reviewed - Added ☐ Reviewed - D/C	☐ Reviewed - Added ☐ Reviewed - D/C
		☐ Reviewed - Added ☐ Reviewed - D/C	☐ Reviewed - Added ☐ Reviewed - D/C
		☐ Reviewed - Added ☐ Reviewed - D/C	☐ Reviewed - Added ☐ Reviewed - D/C
		☐ Reviewed - Added ☐ Reviewed - D/C	☐ Reviewed - Added ☐ Reviewed - D/C

POS Reorder # 1916504