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

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

Grapevine Office
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

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 ________________________
DOB ________________________
Address ________________________
____
Cell Phone________________________
Employer________________________
Work Phone________________________
Home Phone ________________________
Email________________________

Parents Name________________________
DOB ________________________
Address ________________________
____
Cell Phone ________________________
Employer ________________________
Work Phone ________________________
Home Phone ________________________
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		
☐	☐	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**

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 member	Which relative? (circle one)				
☐	☐	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: