HEARTLAND EYE CONSULTANTS

9900 Nicholas Street ○ Suite 250 ○ Omaha, NE 68114
402-493-6500 ○ Fax: 402-493-4370

To Our Valued Patient:

Welcome to Heartland Eye Consultants! We are looking forward to seeing you and your child for their appointment. Please fill out the New Patient paperwork. We would greatly appreciate your taking the time to fill out these forms at home. This will save valuable time in-office and make available more time with your doctor. Please bring them with you to your appointment.

Please bring the following with you to your appointment:

1. The enclosed Patient Information Forms:
2. Your child's insurance card
3. Your child's co-pay
4. A list of any medications your child takes with the dosages
5. Your child's glasses (Even if they do now wear them)

Please note that all co-payments and applicable yearly deductibles are due at the time of your visit. Please make sure you have a credit card, your check book or cash with you.

This examination will NOT be considered a ROUTINE visit so we will be submitting to your major medical insurance, not your 'vision' or 'eye glasses' insurance.

If your child's insurance requires a referral from your primary care doctor (pediatrician or family doctor, *not* your eye doctor), it is your responsibility to request the referral **before** your appointment at Heartland Eye Consultants. If that is not done **by you** ahead of time, we may have to reschedule your appointment because some doctor's require a day's notice or more to get those completed and faxed to us.

Handicapped Parking and Senior Parking is available on the **west** side of the building. Parking there will eliminate the need to climb stairs.

If you have any questions or need to reschedule your appointment, please call us at (402)493-6500. Thank you for entrusting your vision to us!

Sincerely,
Patient Services

Heartland Eye Consultants
Pediatric Patient Demographics

Last Name: ________________________________ First Name: ___________________________________ M.I. ________

Street Address: ____________________________ Apt #______ Gender: ○M ○F Date of Birth: _______/_______/_______

City: __________ State: _______ Zip Code: __________ Home: (_____) _____________ Soc. Sec. No. ______-_______-_______

Primary Language: ○English ○Spanish ○French ○Other________________ ○I decline.

Race: ○American Indian or Alaska Native ○Asian ○African-American ○Pacific Islander ○White ○Other Race ○I decline

Ethnicity: ○Not Hispanic or Latino ○Hispanic or Latino ○ Other ____________________________ ○I decline.

Special Needs: ○Hearing Impaired ○Wheelchair ○Translator ○None ○ Other ___________________________________

Which doctor referred you to our office? ______________________________ If not, please list _________________________

Who performed your last eye exam? __________________________________ Date: ____/____/_____

Pediatrician/Family Physician: _______________________________________

Emergency Contact: _______________________ Relationship: ______________ Phone: ________________________________
(Not living in household) (Area Code)

Please place an X in the boxes to indicate with whom the child lives:
☐**Father's Last Name**:__________________**First Name**:___________________ M.I.____ Birthdate: _______/_______/________

Address __________________________________ City:_______________________ State:_______ Zip Code:__________________

Cell Phone: (_____)__________________ Home Phone:(______)_________________ Work Phone(________)_________________

Please provide your EMAIL address for appointment purposes only:____

SSN:______________________ Employer: _________________________Occupation_________________Title: ________________

Employer's Address:_______________________ City_____________State______Zip_______ Work Phone___________________

☐**Mother's Last Name**:__________________________**First Name**:_______________ M.I.____ Birthdate: ______/_______/_____

Address _____________________________________ City:__________________ State:________ Zip Code:___________________

Cell Phone: (_____)________________ Home Phone:(______)______________________ Work Phone(________)______________

Please provide your EMAIL address for appointment purposes only:____

SSN:______________________ Employer: _________________________ Occupation______________Title: _________________

Employer's Address:________________________ City_____________State______Zip_________ Work Phone_________________

☐Step-Parent's Last Name: ______________________ First Name:_______________M.I.____ Birthdate: ______/______/________

<u>The person requesting services for a minor is the responsible party.</u>

We will file major medical insurance coverage for you if you provide us with a copy of your current card. For patients without insurance coverage, you will be responsible for payment today by cash, check or credit card. (We accept MasterCard or Visa.)

Photo Release: I hereby grant Heartland Eye Consultants, L.L.C. and Developmental Vision Associates, P.C. permission to have my child's photograph taken for patient information. This does not allow them to use my child's likeness in photographs and/or video in any of its publications or media.

<u>AUTHORIZATION TO RELEASE INFORMATION TO YOUR INSURANCE COMPANY AND ACKNOWLEDGEMENT OF PERSONAL RESPONSIBILITY FOR PAYMENT</u>

I hereby assign all medical benefits (to which my child is entitled) to the doctor caring for my child. This includes major medical benefits, Medicare, Medicaid, private insurance and any health plans in which I am enrolled. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by my insurance and <u>15% APR will be applied to all accounts not paid within 30 days</u>. I hereby authorize the holder of my medical and patient registration records to release any information need to process my insurance claims. I understand that I am the guarantor of this account.

$15 Fee may incur if a copy of my medical records are requested in writing and will be provided whomever I designate.
$25 Fee will incur for all returned checks.
$50 A deposit will be required to schedule an appointment if you fail to keep an appointment or if you repeatedly reschedule your appointment with less than a 48 hour notice. This deposit will be credited to your bill if you keep your appointment as scheduled. However, you will forfeit the deposit if you No Show or reschedule again with less than a 48 hour notice.

Authorized Signature: ____Date of Signature: ________________________
PLEASE INITIAL __________ You have read and are aware of the HIPAA privacy policy and agree with its provisions.

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INFANT/TODDLER/PRE-SCHOOL VISION HISTORY

When completing this for a minor child, please be sure to answer the questions with regard to him/her.
Be careful to *fill in every blank*. This will help your doctor better understand your child's condition.
Please bring it with you to your appointment. Thank you!

First Appointment: ______________________
Day Date Time

CHILD'S FULL NAME______________________________ ☐ Male ☐ Female
DOB____/____/______ AGE: ______years ______ months
Delivery Due Date: __________________________

PARENT'S FULL NAMES:

Mother____ Father____
Step-Mother____________________________________ Step-father____________________________________

VISUAL HISTORY

Why do you believe your child needs a visual examination? ____
____
Has your child's vision been previously evaluated? ☐ Yes ☐ No
If so, Doctor's Name: ______________________________ Date of last evaluation: ______________________
Reason for examination: ____
Results and recommendations: ____
Were glasses, contact lenses, or other optical devices recommended? Yes ☐ No ☐
If yes, what? ____
Are they used? ☐ Yes ☐ No If yes, when? ____
If not used, why not? ____
Was surgery, therapy or other treatment recommend? ☐ Yes ☐ No
If yes, what? ____
____

Members of the family who have had visual problems and the reason:

Name / Relationship	Age	Visual Problem

Please check "yes" or "no" to the following observations and/or complaints as they relate to your child:

	Yes	No	If yes, when?
An eye turns in or out	☐	☐	
Reddened or encrusted eyelids	☐	☐	
Frequent sties	☐	☐	
Eyes in constant motion	☐	☐	
Eyelids droop	☐	☐	
Stares at bright lights or repeatedly flicks objects in front of face	☐	☐	
Is abnormally bothered by bright light	☐	☐	
Seems visually unaware	☐	☐	

DATE OF COMPLETION________________

	Yes	No	If yes, when?
Has watery eyes	☐	☐	________
Turns head to use one eye only	☐	☐	________
Tilts head to one side	☐	☐	________
Moves objects very close to look at them	☐	☐	________
Squints while looking at objects	☐	☐	________
Blinks excessively	☐	☐	________
Has a tendency to rub eyes	☐	☐	________
Covers or closes one eye	☐	☐	________
Stumbles over objects or is clumsy	☐	☐	________
Poor motor control	☐	☐	________
Lacks interest in looking at objects or seeing	☐	☐	________
Unable to see distant objects	☐	☐	________
Unable to transfer object from hand to hand, or crossing the midline of the body	☐	☐	________
Is unable to stack blocks or other objects	☐	☐	________

Does your child verbalize any problems/complaints about his/her eyes or vision? Yes ☐ No ☐
If yes, explain: ____

____

MEDICAL HISTORY

Pediatrician's Name: ____________________ Date of Last Evaluation: ____________
For what reason? ____
Results and recommendations: ____

____

Medications currently using, including vitamins and supplements: ____________________

____

For what condition(s)? ____

____

Are child's immunizations up to date? ☐ Yes ☐ No If no, explain: ____________________
Any reactions to immunization(s)? ☐ Yes ☐ No If yes, explain: ________
Is your child generally healthy? ☐ Yes ☐ No
If no, explain: ____
List illnesses, bad falls, high fevers, etc.:

Age	Severe	Mild	Complications

Are there any chronic problems like ear infections, asthma, hay fever, allergies? ☐ Yes ☐ No
If yes, please list: ____
Has a neurological evaluation been performed? ☐ Yes ☐ No
By whom? ____________________ Results and recommendations: ____________

____

Has a psychological evaluation been performed? Yes ☐ No ☐
By whom? ____________________ Results and recommendations: ____________

____

Has an occupational therapy evaluation been performed? Yes ☐ No ☐
By whom? Results and recommendations: ____
____

Is there any history of the following? (please check if there is a history):

	Patient	Family	Who		Patient	Family	Who
Diabetes	☐	☐	_____	High Blood Pressure	☐	☐	_____
Eye Turn (not straight)	☐	☐	_____	Learning disability	☐	☐	_____
Chromosomal imbalance	☐	☐	_____	Amblyopia (lazy eye)	☐	☐	_____
Glaucoma	☐	☐	_____	Multiple Sclerosis	☐	☐	_____
Other	☐	☐	_____	Epilepsy or seizures	☐	☐	_____

If other, please explain: ____
____

DEVELOPMENTAL HISTORY

Full-term pregnancy? ☐ Yes ☐ No
Did the mother experience any health problems during the pregnancy? ☐ Yes ☐ No
If yes, explain: ____
Normal birth? ☐ Yes ☐ No
Any complications before, during or immediately following delivery? ☐ Yes ☐ No
If yes, explain: ____
Birth weight: _____________ APGAR scores @ birth: ______________ After 10 minutes: ______________
Were there any difficulties at all in feeding (such as difficulty with sucking, vomiting?) ☐ Yes ☐ No
If yes, explain: ____
Any problems with colic? ☐ Yes ☐ No
Was there ever any reason for concern over your child's general growth or development? ☐ Yes ☐ No
If yes, why? ____
Has your child received any special developmental guidance/ assistance/therapy? ☐ Yes ☐ No
If yes, explain: ____
How many hours daily does your child sleep? ____
Does your child sleep through the night? ☐ Yes ☐ No If yes, starting at what age: ______________________
If no, explain: ____
What percent of the *waking* hours is/was your child in a playpen/crib/carseat? ______________________________

In a walker? ___________

In a seat? ___________

What things can your child do very well? ____
____
What things, if any, are difficult for your child? ____
____

NUTRITIONAL INFORMATION

Current Diet: ☐ Breast Fed ☐ Breast Fed until what age: ___________ ☐ Bottle fed
Solid food started at what age: ___________ What type? ____

Are there any food allergies/sensitivities? ☐ Yes ☐ No
If yes, what: ____
Activity Level: ☐ High ☐ Moderate ☐ Low
Are there periods of very high energy ☐ Yes ☐ No
Are there periods of very low energy? ☐ Yes ☐ No

Does your child: ☐ Like sweets or ☐ Crave sweets

If so, what? ____

What are his/her favorite foods? ____

What are his/her disliked/avoided foods? ____

PRE-SCHOOL

If your child attends pre-school, please fill out the following:

Name of Pre-school: ________________ Teacher: __________ Director: ____________

Age at time of entrance to pre-school: _________

Does your child like pre-school? ☐ Yes ☐ No

Does your child like the teacher? ☐ Yes ☐ No

Compared to other children his/her age, do his/her general performance and social skills seem to be

☐ above ☐ equal to ☐ below

Please explain: ____

Which pre-school activities are easy for your child? ____

____

Which pre- school activities are difficult for your child? ____

____

Specifically describe any pre-school / day care concerns / difficulties: _________

____

____

Does your child seem to be under tension at pre-school/day care? ☐ Yes ☐ No

If yes, explain: ____

____

CURRENT ABILITIES/BEHAVIOR

List the age at which your child could do the following: (Mark N/A if your child has not yet accomplished these behaviors/abilities).

	Age		Age
Responsive smile	______	Stack blocks	______
Crawl (stomach on floor)	______	Walk alone	______
Roll over	______	Scribble spontaneously	______
Creep (stomach of floor)	______	Kick a ball	______
Sit up alone	______	Walk up steps with help	______
Respond to words and names	______	Use two-word sentences	______
Say single words	______	Toilet-trained	______
Give first name	______	Put on some clothing alone	______

Can your child identify colors? Yes ☐ No ☐ If yes, which? ____________________

Can your child identify numbers or letters? Yes ☐ No ☐ If yes, which? ____________________

Does your child like to draw/color? Yes ☐ No ☐

Is your child learning to read? Yes ☐ No ☐

How is your child performing compared to others his/her age:

☐ Above average ☐ Average ☐ Below average

How well developed is your child's spoken vocabulary? ____________________

How well does your child understand/respond to spoken language? ____________________

Check the appropriate spaces if you have any concerns about the following behavior(s) in your child:

Lack of curiosity	☐	Irritable, easily upset	☐
Thumb-sucking	☐	Restlessness	☐
Nervous	☐	Has difficulty separating from parents	☐
Glum, sulky, moody	☐	Sleeplessness	☐
Bad temper	☐	Lethargic, low energy	☐
Passive	☐	Aggressive	☐

Other (please explain): ____

____

GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:

____
____
____
____
____
____
____

Is there any other information that would be helpful or important in our evaluation or treatment of your child?

____
____
____
____
____
____
____

Who completed this form?

☐Mother ☐Father ☐Step-Mother ☐Step-Father ☐Adoptive Parents ☐Foster Parents ☐ Grandmother ☐Grandfather ☐Aunt ☐Uncle ☐Other Caretaker (please specify)________________

______________________ Signature

______________________ Date of Completion