



Welcome to our Practice

We are pleased that you have chosen to come to our office for your eye care needs. Each patient's needs remain the primary focus of our team. The mission of our practice is to meet your comprehensive visual and ocular health needs and to exceed your expectations in a friendly, compassionate, educational atmosphere, nurturing a lasting relationship with you.

People are sometimes misled into thinking eye care is the same from one place to another, but it's not. Seeing the eye chart is one thing, but vision and medical eye health care varies dramatically. We see it as total vision and medical eye health. We want you to know that we are not only concerned about your current vision, but maintaining good vision for many years to come. In order to adequately assess the overall health of your eyes, we often need to dilate your eyes. The dilating drops may cause blurry vision and light sensitivity. These side effects may last 3-6 hours depending on your eye color and age. You may want to bring along a driver to be present when your eyes are dilated.

Although we do our best to stay on schedule, sometimes delays cannot be avoided due to the complexity of our patients' cases or emergencies that the doctor has to work into his/her schedule. We apologize for any wait time that you may experience, but please understand that your time is very important to us and the doctor will spend as much time with you as needed to answer all your questions and provide a thorough diagnosis and plan for you.

What to Bring to Your Appointment

All Patients:

1. Picture ID (for adults), Vision and Medical Insurance Card
2. Current eyeglasses and sunglasses
3. List of Medications
4. Completed Health and History Form

Contact Lens Patients:

1. Current contact lens prescription and the brand of your lenses.

Please fill out the enclosed paperwork and bring it along with the above mentioned items in order to expedite the check-in process on the day of your appointment.

All estimated professional fees are due at the time of service. Please be prepared to pay your copay and any coinsurance on the day that eye care is received. If necessary, we will send you a statement for any overage after your insurance has been processed.

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The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Pediatrician _____
Town _____
Date of Last Physical Check-up _____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills) _____

Allergies to any medications? Yes No
If so, what medications? _____

Preferred Pharmacy _____
Street _____
City: _____

Has your child had any major surgeries? Yes No
Please list _____

Have you ever been diagnosed or treated for the following health problems?

- | | |
|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Blood/Lymph | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Digestive | <input type="checkbox"/> Eczema/Rashes |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Genitourinary | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Integumentary (Skin) | <input type="checkbox"/> Kidney |
| <input type="checkbox"/> Muscle/Bone | <input type="checkbox"/> Neurological |
| <input type="checkbox"/> Psychological | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Thyroid | |

Patient Eye History

Date of Last Eye Exam _____
By Whom? _____

Does child currently wear contact lenses?

Yes No

What kind? _____

Solutions used _____

Is your child satisfied with the vision and comfort of your contact lenses? Yes No

If you don't wear contacts, would you be interested in being fit for them Yes No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:

- | | Relationship to your child |
|----------------------|--------------------------------|
| Blindness | <input type="checkbox"/> _____ |
| Cataracts | <input type="checkbox"/> _____ |
| Corneal Problems | <input type="checkbox"/> _____ |
| Diabetes | <input type="checkbox"/> _____ |
| Glaucoma | <input type="checkbox"/> _____ |
| Heart Disease | <input type="checkbox"/> _____ |
| Lazy Eye | <input type="checkbox"/> _____ |
| Macular Degeneration | <input type="checkbox"/> _____ |
| Retinal Problems | <input type="checkbox"/> _____ |

Mother's Pregnancy History (Did any of the following occur?)

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Infection | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Drug Use | <input type="checkbox"/> Premature Delivery |
| Other _____ | |

Please be advised if you are using insurance coverage for today's visit, we require a valid copy of your insurance card to ensure that your claims are filed properly. We will file your insurance for you as a courtesy, however if your insurance does not cover a particular service, you will be responsible for the balance, any copays, deductibles, and/or contact lens fitting fees. Payment of these is due at the time of the service.

By signing, you authorize your insurance company to make payment to this practice for services and material provided. You authorize the practice to deposit checks received on your account if made out to you, the patient. You authorize the practice to initiate a complaint to the Insurance Commissioner for any reason on your behalf.

Parent/Guarantor Signature _____ Date: _____

EYES ON HENRY

Pediatric History Form

Patient Information	Insurance Information
<p>Today's Date _____</p> <p>Child's Last Name _____ First _____ MI _____</p> <p>Preferred Name _____</p> <p>Street _____</p> <p>City _____ State _____</p> <p>Zip Code _____</p> <p>Home Phone _____</p> <p>Parent/Guarantor Name _____</p> <p>SSN _____ Date of Birth _____</p> <p>Work Phone _____ Cell Phone _____</p> <p>Email _____</p> <p>Child's SSN _____</p> <p>Date of Birth _____</p> <p>Sex M F</p> <p>School _____ Grade _____</p>	<p>Vision Insurance _____</p> <p>Policy/ID Number _____</p> <p>Group Number _____</p> <p>Subscriber's Name _____</p> <p>Subscriber's SSN _____</p> <p>Subscriber's Birth Date _____</p> <p>Subscriber's Employer _____</p> <p>Primary Medical Insurance _____</p> <p>Policy/ID Number _____</p> <p>Group Number _____</p> <p>Subscriber's Name _____</p> <p>Subscriber's SSN _____</p> <p>Subscriber's Birth Date _____</p> <p>Secondary Medical Insurance _____</p> <p>Policy/ID Number _____</p> <p>Group Number _____</p> <p>Subscriber's Name _____</p> <p>Subscriber's SSN _____</p> <p>Subscriber's Birth Date _____</p>
<p>What is the major purpose of this visit?</p> <p>_____</p> <p>_____</p> <p>VERY IMPORTANT! NEW PATIENTS ONLY: Who may we thank for referring you to our office? Name of friend or relative _____</p> <p>If not referred, how did you choose our office?</p> <p><input type="checkbox"/> Another Dr. <input type="checkbox"/> Insurance List</p> <p><input type="checkbox"/> Saw Sign/Building <input type="checkbox"/> Yellow Pages</p> <p><input type="checkbox"/> Other _____</p>	<h3>Lifestyle Questions</h3>
<p><i>The mission of this practice is to meet our patients' comprehensive visual and ocular health care needs and exceed their expectations in a friendly, compassionate, and educational atmosphere, nurturing lasting relationships with patients of all ages.</i></p>	<p>Does your child... (check box if your answer is yes)</p> <p><input type="checkbox"/> spend time on electronic devices? How many hrs/day? ____</p> <p><input type="checkbox"/> complain about glare or light sensitivity?</p> <p><input type="checkbox"/> spend time outdoors? How many hrs/week? ____</p> <p><input type="checkbox"/> have sun wear (prescription and/or non-prescription)?</p> <p><input type="checkbox"/> prefer not to wear your glasses at times?</p> <p><input type="checkbox"/> have a spare pair of glasses in their current Rx?</p> <p><input type="checkbox"/> have family members or friends in need of eye care?</p> <p>Has your child ever experienced, been diagnosed or treated for any of the following?</p> <p><input type="checkbox"/> Blurry Vision <input type="checkbox"/> Flashes of Lights</p> <p><input type="checkbox"/> Sunlight Sensitivity <input type="checkbox"/> Eye Infections</p> <p><input type="checkbox"/> Trouble seeing at night <input type="checkbox"/> Eye Injury</p> <p><input type="checkbox"/> Itchiness <input type="checkbox"/> Crossed eye/Eye Turn</p> <p><input type="checkbox"/> Burning <input type="checkbox"/> Lazy Eye</p> <p><input type="checkbox"/> Tearing <input type="checkbox"/> Double Vision</p> <p><input type="checkbox"/> Dry Eyes</p> <p><input type="checkbox"/> Other eye disorders _____</p>

Authorization for Release of Information

This form authorizes Eyes on Henry to release protected information about the patient named below to the people listed (e.g. spouse, parent, sibling) by means of phone calls and voice mail/answering machine messages.

I consent to the release of (please check all that apply):

Financial/Billing Information

Medical Care (treatment plans, medications, procedures, appointments, test results, etc.)

This information may be released to the following:

Patient's voice mail/answering machine

Voice mail/answering machine of (e.g. spouse, parent, sibling)

Name/Relationship to patient

Phone#

Name/Relationship to patient

Phone#

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in the document by sending a written notification to Eyes On Henry. I understand a revocation is not effective in cases where the information has already been disclosed.

I understand that information used or disclosed because of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing This authorization shall be in effect until revoked by the patient.

(Signature of Patient (parent or legal guardian if patient is a minor))

Acknowledgement of Notice of Privacy Practices

Eyes on Henry will provide me a copy of their Notice of Privacy Practices up request.

(Please initial)