The Eye Care Group
Excellence and Compassion in Eye Care

PEDIATRIC PATIENT INFORMATION TO BE COMPLETED IN FULL

Patient's Name: _____ _____ Male: _____ Female: _____
(Last) (First and Preferred)

Age: _____ Date of Birth: _____/_____/_____

Please Circle: *This information is requested due to Healthcare Reform laws dictated by Congress.*
Race: American Indian Asian Black Multi-racial Native Hawaiian White
Ethnicity: Hispanic/Latino Non-Hispanic/non-Latino
Preferred Language: English Spanish Other: _____

Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Social Security #: _____

Father's Name: _____ Marital Status: S M W D SEP
Home Address: _____ ***(if different from patient)***
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Social Security #: _____
Father's Employer: _____ Position:_____
Work Phone #: _____ Date of Birth: _____
Cell Phone #: _____ Email Address: _____

Mother's Name: _____ Marital Status: S M W D SEP
Home Address: _____ ***(if different from patient)***
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Social Security #: _____
Mother's Employer: _____ Position:_____
Work Phone #: _____ Date of Birth: _____
Cell Phone #: _____ Email Address: _____

Emergency contact: _____ **Phone:** _____
(Name and number of person other than parent or guardian)

Whom can we thank for recommending us?
Name:_____ Address:_____
City: _____ State: _____ Zip Code: _____

Child's primary care physician: _____ **City:** _____

Primary Insurance Company: _____
Individual ID #: _____ Group #: _____
Insurance Co. Address: _____ City/State/Zip: _____
Policyholder's Name: _____ Date of Birth: _____

Secondary Insurance Company: _____
Individual ID #: _____ Group #: _____
Insurance Co. Address: _____ City/State/Zip: _____
Policyholder's Name: _____ Date of Birth: _____

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Patient Name: _____

Chart Number: _____ Date of Birth: _____

I understand that it is my responsibility to check with my insurance company to verify what my policy may or may not cover.

I accept full financial responsibility for any charges incurred today if:

1. The services rendered or supplies used/purchased are not covered under my insurance plan;
2. My insurance plan requires that I pay a deductible, co-payment, or co-insurance;
3. There are charges that have resulted because I have failed to provide current and valid insurance policy information; or
4. My insurance plan requires that I obtain a referral prior to my visit and I do not have one in place.

I agree:

1. Payment be made to The Eye Care Group, PC (TECG) by my insurance carrier for services rendered or product received;
2. TECG may use and disclose medical information about me for services and procedures so they may be billed and collected from an insurance agency or any other third party;
3. To pay for my co-pay and other charges that are not covered by my insurance carrier today or make financial arrangements satisfactory to TECG for payment;
4. If I am not able to pay TECG for balances within 30 days, to pay a 1% interest charge, compounded, per month for my balance.
5. To pay a $15.00 service fee for any copayment not paid at the time of service.
6. To pay for any returned check fees incurred by TECG.
7. If I am the parent/guardian bringing in a child for treatment, that I am responsible for all fees incurred by the child.
8. To pay collection expenses and attorney's fees if my account is sent to the collection agency or an attorney for collection.
9. To pay for my refraction expense if my insurance does not cover.

Date: _____ Signature: _____

The Eye Care Group
Excellence and Compassion in Eye Care

Medical Record # _____
(office use only)

PEDIATRIC MEDICAL INFORMATION

(Infant to 17 Years Old)

Date ___/___/___

Child's name: _____, _____
(last) (first and preferred)

Chief concern about child's eyes: _____

_____

When did symptoms start? _____

FAMILY HISTORY ***Please circle all that apply. If "yes", please provide information.***

Do any of the following run in your family:

Crossed eyes	YES	NO
Amblyopia (lazy eye)	YES	NO
Birth defects	YES	NO
Neurological disease	YES	NO
Other childhood disease	YES	NO

NAME	RELATION	DISEASE

Number of brothers and/or sisters and their ages: _____

_____

BIRTH HISTORY ***Please circle all that apply. If "yes", please provide information.***

Was the patient premature?	YES	NO
Birth weight _____ Weeks of gestation _____		
Were there any problems with the pregnancy?	YES	NO
Was there any trouble with delivery?	YES	NO
Was there any breathing or feeding problem in the first few months?	YES	NO
Was there any trouble or delayed sitting, walking, talking, or development?	YES	NO
Are there any unresolved school difficulties?	YES	NO

_____

_____

MEDICAL HISTORY ***Please circle all that apply. If "yes", please provide information.***

Has the patient's primary care doctor suspected or diagnosed
any **serious illness**? ..... YES NO

Does the patient take **medication** or treatments frequently
or regularly? If yes please list medication on lines below. ..... YES NO

MEDICATION	STRENGTH	HOW MANY TIMES A DAY?

Is he/she known to be **allergic** to any medications? ..... YES NO
to any environmental conditions? ..... YES NO

If yes list _____

Has the patient had all the age appropriate
immunizations (up to age 16)? ..... YES NO

Has the patient's growth and development, such as fine motor control, gross motor control, speech, etc., been within normal limits?
YES_____ NO_____ **(If your answer is no, give details below on the blank lines)**

_____

_____

Please circle all that apply.
Is your child receiving: physical occupational speech therapy?

EYE HISTORY ***Please circle all that apply. If "yes", please provide information.***

Has the patient ever been seen by another eye Dr.?..... YES NO

By _____ Date of last exam _____

Has he/she ever had an eye injury?..... YES NO
an eye operation?..... YES NO
Are glasses worn? ..... YES NO
Age first worn _____
Are contact lenses worn?..... YES NO
Age first worn _____

SCHOOL HISTORY ***If your child is in school please circle.***

Are there any unresolved difficulties in school?..... YES NO

Grade _____

Does the child currently have any problems in the following areas? Please circle all that apply. If "yes", please provide information in space provided at end of list.

CONSTITUTIONAL SYMPTOMS

Fever	YES	NO	Fatigue	YES	NO
Weight Loss	YES	NO			

EYES

Loss of vision	YES	NO	Itching	YES	NO
Blurred vision	YES	NO	Burning	YES	NO
Distorted vision	YES	NO	Excess tearing	YES	NO
Mucous discharge	YES	NO	Light sensitivity	YES	NO
Redness	YES	NO	Eye pain	YES	NO

EAR, NOSE, MOUTH, THROAT

Sinus disease	YES	NO	Difficulty learning	YES	NO

RESPIRATORY

Chronic cough	YES	NO	Asthma	YES	NO

CARDIOVASCULAR

Heart murmur	YES	NO	Rapid or irregular heartbeat	YES	NO

GASTROINTESTINAL

Hepatitis	YES	NO	Bowel disease	YES	NO
Diarrhea	YES	NO			

GENITOURINARY

Bladder infections	YES	NO

MUSCULOSKELETAL

Muscle pain	YES	NO	Joint pain	YES	NO
Arthritis	YES	NO			

PSYCHIATRIC

Depression	YES	NO	Anxiety	YES	NO

ENDOCRINE

Excessive thirst	YES	NO	Intolerance to heat	YES	NO

Please circle all that apply. If "yes", please provide information.

NEUROLOGICAL

Learning Disabilites	YES	NO	Headaches	YES	NO
Seizures	YES	NO	Weakness arms/legs	YES	NO
Strokes	YES	NO	Speech problems	YES	NO
Migraine	YES	NO	Dizziness	YES	NO
Difficulty chewing	YES	NO	Difficulty swallowing	YES	NO

Please circle all that apply. If "yes", please provide information.

HEMATOLOGIC/LYMPHATIC

Blood disease	YES	NO	Bleeding problems	YES	NO
Anemia	YES	NO	Leukemia	YES	NO

ALLERGIC/IMMUNOLOGIC

Seasonal allergies	YES	NO	Hives	YES	NO
DRUG EXPOSURE	YES	NO	**AIDS/HIV**	YES	NO

Explanation of Problem: _____

_____

_____

Does the patient have any medical problems or symptoms we have not asked you about?

YES ____ NO ____ ***If "yes", please provide information:***

_____

_____

_____

_____

_____

Information Reviewed By:

Initials: Date:

All information on this form is confidential.

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