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: _____/_____/_____

The person requesting services for a minor is the responsible party.

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.

AUTHORIZATION TO RELEASE INFORMATION TO YOUR INSURANCE COMPANY AND ACKNOWLEDGEMENT OF PERSONAL RESPONSIBILITY FOR PAYMENT

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 15% APR will be applied to all accounts not paid within 30 days. 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.**

Heartland Eye Consultants
9900 Nicholas Street, Omaha, NE 68114 (402)493-6500 Fax: (402-493-4370

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