Patient Registration

Patient's Full Name _____ Today's Date ____

Nickname or Preferred Name _____ Birthdate _____

Gender: M F Language: English Spanish Other: _____Soc. Sec. _____

Race/Ethnicity: __White __Black or African American __Hispanic/Latino __American Indian
__Asian __Native Hawaiian or other Pacific Islander

Marital Status: Single Married Widowed Separated Divorced

Occupation: _____ Student: Yes No

Address _____

Phone:Primary_____ Other _____

Email:_____

Name(s) of Parent/Guardian _____ Occupation _____
(if minor) _____ Occupation _____

Emergency Contacts_____ Phone:_____ Relation:_____
_____ Phone:_____ Relation:_____

Other Family Members who are current Patients:_____
_____

**********CONSENT TO RELEASE MEDICAL INFORMATION**********

I, _____, authorize the person(s) listed below to have knowledge of medical information, including, but not limited to eye exams, office visits, treatment, and/or visual rehabilitation therapy when I am not immediately available in person, or by a telephone call for: _____(name of patient).

Persons who may have access to the medical history of the above named patient:

Name:_____Relation to patient:_____Phone:_____

Name:_____Relation to patient:_____Phone:_____

Name:_____Relation to patient:_____Phone:_____

X _____ _____ _____

Patient or Responsible Party Signature Print Name Date

**this consent is effective until withdrawn in writing

Continued Patient Registration

Guarantor Information: (Person responsible for the account)

Name: _____ Soc. Sec. #_____

Birth Date: _____ Address: _____

Patient Relationship to Guarantor: ___Self ___Child ___Spouse ___Other:

Primary Insurance:

Holder Name _____ DOB ____/_____/_____ Soc Sec._____

Plan Name: _____ID #_____ Group_____

Patient Relationship to Guarantor: ___Self ___Child ___Spouse ___Other:

Secondary Insurance:

Holder Name _____ DOB ____/_____/_____ Soc Sec._____

Plan Name: _____ID #_____ Group_____

Patient Relationship to Guarantor: ___Self ___Child ___Spouse ___Other:

**********CONSENTS**********

Consent to Treatment: I consent to treatment services including performance of examination, diagnostic procedures, and rendering of treatment by the physician or clinical assistants by direct order of the physician. Services may encompass examination and medical or visual treatment, and administration of medications as ordered by the physician.

Notice of Privacy Practices: I acknowledge that I have read and understand the Notice of Privacy Practices which is posted at the office location where treatment is conducted, is made available at check in, and is available online at www.arkansasvision.com.

Notice for Filing Insurances: I understand that I am financially responsible for all services incurred today. This financial responsibility includes any deductible, co-insurance, non-covered services.

I agree that the insurance information given to you today is current and should I have out of network Primary and/or Secondary insurance, that I am responsible for the cost of today's visit. I understand that payment is due at the time services are rendered, and that I am to furnish any and all explanation of benefits upon receipt of same to the doctor's office for filing of my secondary insurance, should it apply.

I hereby authorize release of medical information necessary to file a claim with my insurance with benefits made on my behalf to Arkansas Vision Development Center for services rendered.

X _____ _____

Patient or Responsible Party Signature Date

Medical History

Patient's Full Name _____ Birthdate _____

What is the reason for this examination?_____

_____

Do you currently have any problems in the following areas? If yes, please circle and explain.

Eye Turn	Eye Infection	Blurry vision	
Squinting	Redness	Loss of vision	
Eye Pain	Burning	Flashes of Light	Glaucoma
Headache	Itching	Floaters	Retinal Condition
Double Vision	Sandy/Gritty	Decreased Vision	Cataracts
Drooping Eyelid	Dry Eyes	Light Sensitivity	

Explanation _____

_____

Date of last eye exam _____ Date of last eye dilation _____

Have you ever been diagnosed with any eye conditions? _____

Primary Care Doctor _____ Referred By _____

Medical Conditions _____

_____

Medications _____

Medication Allergies _____

Surgeries (include any eye surgeries) _____

Hospitalizations (reason & year) _____

Injuries (include eye injuries)_____

Allergies (seasonal or food) _____

Reactions to immunizations _____

Glasses: Have you been prescribed glasses? N Y - Please bring them to your exam.

If yes, how often do you wear your glasses? _____

Are you having any problems with wearing glasses? _____

Contacts: Do you wear contact lenses? N Y - Please bring your contact lens boxes to your exam.

If yes, how often do you change out your contacts? _____

Do you sleep in your contacts? N Y

Continued Medical History

Social/Other Information:

Who does the patient live with? _____

Sports or Other Hobbies_____

Do you work on a computer? ____ Hours/day.

Do you use Tobacco? □No □Yes-What form and how much? _____

Do you drink Alcohol? □No □Yes-How much? _____drinks per day □ Occasional

Patient Review of Systems: Please indicate each area that applies to the patient and explain.

Eye Conditions	N Y	
ENT (ears, nose, throat conditions)	N Y	
General (such as fatigue or malaise)	N Y	
Pulmonary (apnea, cough, lung condition)	N Y	
GI (nausea, vomiting, intestinal or stomach)	N Y	
GU (dysuria,	N Y	
Skin (rash, eczema, etc)	N Y	
Psych (anxiety, depression, mood related)	N Y	
Neurologic (migraines, seizures, attention deficit)	N Y	
Musculoskeletal (muscle dystrophy, joint pain)	N Y	
Cardiovascular (chest pain, high blood pressure)	N Y	
Endocrine (Diabetes, thyroid)	N Y	
Gynecologic (pregnancy, etc)	N Y	
Hematology (anemia, bruising, bleeding disorder)	N Y	

Family Medical History: Please circle each condition that applies to the patient's family member.
M=Mother F=Father S=Sibling GM=Grandmother GF=Grandfather

Lazy Eye	N Y	M	F	S	GM	GF		
Eye Turn	N Y	M	F	S	GM	GF		
Blindness	N Y	M	F	S	GM	GF		
Glaucoma	N Y	M	F	S	GM	GF		
Other Eye Conditions	N Y	M	F	S	GM	GF		
Asthma	N Y	M	F	S	GM	GF		
Bleeding Disrders	N Y	M	F	S	GM	GF		
Cancer	N Y	M	F	S	GM	GF		
Diabetes	N Y	M	F	S	GM	GF		
Drug/Alcohol Addiction	N Y	M	F	S	GM	GF		
Heart Disease	N Y	M	F	S	GM	GF		
High Blood Pressure	N Y	M	F	S	GM	GF		
Emotional or Mental Condition	N Y	M	F	S	GM	GF		
Stroke	N Y	M	F	S	GM	GF		

Continued Medical History: Pediatric

Birth/Pregnancy History: Delivery was: □ Normal □ C Section

Were there problems During Pregnancy? □Yes □No During Delivery? □Yes □No

During Labor? □Yes □No Immediately Following Birth? □Yes □No

If yes, please explain: _____

Your child was delivered: □ On Time □ Early - How early? _____ □ Late

Birth weight: _____ pounds _____ ounces Apgar Score (if known) _____

Developmental History:

Meeting developmental milestones? Yes No Explain_____

Crawled by (age) _____ Walked by (age) _____ Handed: Right/Left

Receiving therapies? (please circle) Occupational Speech Vision Physical Behavioral Resource Tutoring

School Information:

Name of Child's School _____ Grade _____

Name of Child's Teacher _____

1. Date entered kindergarten: _____ (mo.) _____ (yr.) Age _____

   Date entered first grade: _____(mo.) _____ (yr.) Age _____

2. Does your child enjoy school? □Yes □No

   Does your child like his/her teacher? □Yes □No

   Is school attendance regular? □Yes □No

   Explain _____

3. Has your child ever repeated any grade? □Yes: grade_____ □No

4. In your opinion, what is your child's favorite school subject? _____

   Easiest subject? _____ Hardest subject? _____

5. Has your child had any remedial work? □Yes □No

   If Yes, when? _____ In what subject? _____ From whom?_____

6. Has your child changed schools or teachers? □Yes □No

   If Yes, how often? _____ When and why? _____

7. Has your child ever had: Educational testing □Yes □No

   Psychological or audiological testing □Yes □No

   Medical special testing (non-routine) □Yes □No

   If Yes, when? _____ Explain: _____

8. Is your child receiving any special educational services? □Yes □No

   If Yes, what is the service? _____

Arkansas Vision Development Center

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19 Item COVD-QOL Checklist Questionnaire

Name: _____ DATE: _____ GRADE LEVEL: _____

Check the column which best represents the occurrence of each symptom

	NEVER	SELDOM	OCCASIONAL	FREQUENTLY	ALWAYS
Headaches with near work					
Words run together reading					
Burn, itch, watery eyes					
Skips/repeats lines reading					
Head tilt/close one eye when reading					
Difficulty copying from chalkboard					
Avoids near work/reading					
Omits small words when reading					
Writes up/down hill					
Misaligns digits/columns of numbers					
Reading comprehension down					
Holds reading too close					
Trouble keeping attention on reading					
Difficulty completing assignments on time					
Always says *I can't* before trying					
Clumsy, knocks things over					
Does not use his/her time well					
Loses belongings/things					
Forgetful/poor memory					

Please list any therapies the patient is currently in and where (such as Occupational, Physical, and Speech):

_____

OTHER COMMENTS: