children's
EYE CARE

PEDIATRIC OPHTHALMOLOGY + ADULT STRABISMUS

John D. Baker, MD
John D. Roarty, MD
Rajesh C. Rao, MD
Lisa I. Bohra, MD
Leemor B. Rotberg, MD
Elena M. Gianfermi, MD
Alexandra O. Apkarian, MD

Welcome!

We would like to thank you for choosing our office for your eye care needs. This information is to assist you with any questions and help you prepare for your visit with us.

You're probably wondering why you, or your developmentally delayed adult child, has been referred to an eye doctor that is fellowship trained in pediatrics. It's because pediatric ophthalmologists have the most training in all of the eye care community in areas like double-vision and strabismus. They are also uniquely trained to work with patients that are non-verbal. **What to expect for a visit with us** will depend on the patient's needs, but it will usually focus primarily on the evaluation of strabismus and double-vision. Typically, this doesn't require us to dilate the pupils. However, we occasionally do need to if we're concerned about certain retinal causes of double-vision. Therefore, if you have trouble driving when dilated, you may want to consider having someone accompany you. Also, we are rarely handling your actual glasses prescription for myopia, hyperopia, astigmatism and presbyopia; that's the role of your regular eye doctor. Instead, if we're handling any aspect with your glasses because you have double-vision, we're addressing that with prisms that get added to your normal prescription from your regular eye doctor.

BRING TO YOUR FIRST APPOINTMENT

All medical insurance cards (we do NOT participate with vision insurance), driver's license or state identification.
Medical History, Current Medications, Registration forms.
If applicable: Glasses, contact lenses, contact lens box and/or name.
If your insurance company requires authorizations from your primary doctor, remember every visit needs prior approval.
Cash, check or credit card (MasterCard, Visa or Discover) to pay for any services not covered by your insurance company.

YOU AND YOUR INSURANCE

CO-PAYS AND DEDUCTIBLES

Our contract with your insurance company requires that we collect any known co-pays and/or deductibles. We are in violation of our contract if we don't collect these fees. We will be collecting these fees at your visit. Please be prepared to pay at this time.

REFRACTIONS

While we rarely provide refractions (that's the test/process your regular eye doctor normally does to check to see what type of prescription you need for any myopia, hyperopia, astigmatism and presbyopia and you often have to pay for separately as many medical insurance plans don't pay for it), it is occasionally something we have to address. It's important to know that some insurance companies may not pay for refractions to determine if the patient needs glasses or has a refractive disorder (or pathology). Therefore, it could be an out-of-pocket cost to patients. We will attempt to bill your medical insurance plans (we do NOT participate with vision plans) for this test. Our fee is $30.00

If the patient is new, how did you hear of us: **PATIENT REGISTRATION FORM FOR ADULTS**

PATIENT'S LAST NAME	FIRST NAME	MIDDLE	GENDER	BIRTHDATE	SOCIAL SECURITY #

The Center of Medicare and Medicaid Services requires that we collect the patient's race, ethnicity and primary language.

RACE	ETHNICITY	LANGUAGE PREFERENCE:

FULL STREET ADDRESS WHERE PATIENT LIVES	CITY, STATE AND ZIP WHERE PATIENT LIVES

MOBILE # WHERE PATIENT LIVES	HOME # WHERE PATIENT LIVES	EMAIL ADDRESS	Would you like to communicate with the office via email?
( )	( )		☐ Yes ☐ No

Can you we send you appointment reminders via text message?	OTHER/EMERGENCY PHONE NUMBER	ALTERNATE PHONE LOCATION
☐ Yes ☐ No	( )	□ WORK □ FAMILY/OTHER:_____

FAMILY DOCTOR/INTERNIST NAME	ADDRESS/CITY/STATE/ZIP	PHONE NUMBER

REFERRING DOCTOR'S NAME (IF DIFFERENT)	ADDRESS/CITY/STATE/ZIP	PHONE NUMBER

OPTOMETRIST/OPHTHALMOLOGIST'S NAME	ADDRESS/CITY/STATE/ZIP	PHONE NUMBER

GUARDIAN INFORMATION IF ADULT PATIENT IS DEVELOPMENTALLY DELAYED

MOTHER/GUARDIAN'S LAST NAME	FIRST NAME	CHECK ONE	BIRTHDATE	SOCIAL SECURITY #
		□Biological Mother □Adopted Mother □Step-Mother □Foster Mother □Legal Guardian		

EMPLOYER'S NAME	EMPLOYER'S ADDRESS	EMPLOYER'S PHONE #

FATHER/GUARDIAN'S LAST NAME	FIRST NAME	CHECK ONE	BIRTHDATE	SOCIAL SECURITY #
		□Biological Father □Adopted Father □Step-Father □Foster Father □Legal Guardian		

EMPLOYER'S NAME	EMPLOYER'S ADDRESS	EMPLOYER'S PHONE #

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO FAMILY/FRIENDS

To make it easier to discuss medical care about you with those that help you with care, we ask that you complete this form.
It is NOT necessary for you to give us permission to provide medical information to your other doctors. Example of who needs permission for us to talk to would be spouses/partners, children, parents, aunts/uncles, siblings, friends, neighbors, etc. I AUTHORIZE:

PERSON'S NAME:_____ **RELATIONSHIP:**_____ **PHONE #:**_____

PERSON'S NAME:_____ **RELATIONSHIP:**_____ **PHONE #:**_____

PERSON'S NAME:_____ **RELATIONSHIP:**_____ **PHONE #:**_____

PERSON'S NAME:_____ **RELATIONSHIP:**_____ **PHONE #:**_____

I understand that Children's Eye Care (CEC) does NOT participate with VISION insurance. If appropriate, visits will be billed to the medical plan.

CEC may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to CEC for reimbursement for services rendered, and (2) any health care provider for continued patient care. CEC may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to state or federal law, statue or regulation. A copy of this authorization may be used in place of the original. I authorize that my protected health information (also known as PHI) may be used or disclosed with the above-mentioned people. I understand that I have the right to be aware of all PHI that will be disclosed to these people. I understand that Children's Eye Care will not condition any aspect of my treatment or payment I understand that I am under no obligation to sign this Authorization. I understand that this Authorization may be revoked in writing at any time by my signing the revocation section below and returning it to Children's Eye Care unless: they have previously acted in reliance on this Authorization. By my signing the Authorization, I acknowledge that I have read and understand this Authorization. Further, I give my authorization to Children's Eye Care to use or disclose PHI in accordance to the terms of the Authorization. **Financial Agreement:** I agree that in return for the services provided to the patient by CEC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to CEC for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to CEC. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to CEC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. Also, I agree to reimburse CEC the fees of any collection agency , which may be based on a percentage at a maximum of 32% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

SIGNATURE: _____ DATE:_____

PATIENT'S PRINTED NAME: _____

PATIENT NAME _____ DATE_____

IF YOU WEAR EYEGLASSES, HOW OLD WERE YOU WHEN YOU STARTED WEARING THEM?_____ HOW OLD IS THE PRESCRIPTION?_____

IF YOU WEAR CONTACTS, HOW OLD IS THE PRESCRIPTION?_____HOW MANY HOURS PER DAY DO YOU WEAR THEM?_____

IF YOU HAVE BEEN TOLD TO DO EYE EXERCISES, DESCRIBE THE EXCERCISES_____
_____
_____
_____

WHAT IS THE DATE OF YOUR LAST DILATED EYE EXAM?_____ WHO DID THE EXAM?_____

REVIEW OF SYSTEMS - PLEASE CHECK EITHER YES OR NO * DO NOT LEAVE ANY UNANSWERED

HAVE YOU RECENTLY HAD: A FEVER ☐ YES ☐ NO UNINTENTIONAL WEIGHT LOSS ☐ YES ☐ NO

DO YOU? SMOKE ☐ YES ☐ NO USE RECREATIONAL DRUGS ☐ YES ☐ NO ABUSE ALCOHOL ☐ YES ☐ NO

ARE YOU HAVING ANY OF THE FOLLOWING DIFFICULTIES: _____

YES NO IF YOU ANSWER YES TO THE FOLLOWING SEVEN QUESTIONS, DESCRIBE THE SYMPTOMS/ISSUES YOU'VE HAD WITH THESE ISSUES

☐ ☐ DOUBLE VISION: IF YES, WHEN DID IT BEGIN:_____
IF YOU GET DOUBLE-VISION,
☐ YOU NOTICE IT WHEN LOOKING AT FAR DISTANCES (DRIVING, WATCHING TV, PLAYING SPORTS, ETC)
☐ YOU NOTICE IT WHEN LOOKING AT NEAR RANGES (READING, USING COMPUTER, DOING FINE HANDIWORK LIKE KNITTING, ETC.)
☐ YOU NOTICE WHEN LOOKING A FAR AND NEAR RANGES
☐ YOU CLOSE YOUR EYE FOR COMFORT. IF SO, WHICH EYE: ☐ RIGHT ☐ LEFT

IF YOU GET DOUBLE VISION, DO YOU FEEL THAT IT'S (CHOOSE ONE): ☐ IMPROVING ☐ WORSENING ☐ NO CHANGE

IF YOU GET DOUBLE VISION, DO YOU HAVE PRISM(S) IN YOUR GLASSES? ☐ YES ☐ NO

YES NO
☐ ☐ DISTORTED VISION: IF YES, WHICH EYE. ☐ RIGHT ☐ LEFT
☐ ☐ EYE STRAIN
☐ ☐ MISALIGNED EYES BUT NO DOUBLE VISION
☐ ☐ EYE MISALIGNMENT IN CHILDHOOD
☐ ☐ PREVIOUS EYE MUSCLE SURGERY. IF YES, PLEASE BE CERTAIN TO DOCUMENT SURGERY IN PREVIOUS EYE SURGERY AREA BELOW

YES	NO	*HAVE YOU EVER BEEN TOLD YOU HAVE?*
☐	☐	LAZY EYE/AMBLYOPIA (SINCE CHILDHOOD)
☐	☐	CORNEAL DISEASE
☐	☐	DIABETIC EYE DISEASE
☐	☐	GLAUCOMA
☐	☐	RETINAL DETACHMENT/DISEASE
☐	☐	OTHER_____

YES	NO	*DOES/DID ANY BLOOD FAMILY MEMBER HAVE?*
☐	☐	LAZY EYE/AMBLYOPIA (SINCE CHILDHOOD)
☐	☐	CORNEAL DISEASE
☐	☐	DIABETIC EYE DISEASE
☐	☐	GLAUCOMA
☐	☐	RETINAL DISEASE
☐	☐	OTHER_____

HAVE YOU PREVIOUSLY HAD CATARACT SURGERY OR ANY EYE SURGERIES OR INJURIES (WHAT, WHEN) _____
_____
_____
_____

YES	NO	*HAVE YOU EVER BEEN TOLD YOU HAVE?*
☐	☐	CANCER
☐	☐	DIABETES - ADULT ONSET
☐	☐	DIABETES - CHILDHOOD ONSET
☐	☐	GRAVES/THYROID DISEASE
☐	☐	HEART DISEASE
☐	☐	HIGH BLOOD PRESSURE
☐	☐	HIV/AIDS
☐	☐	PROBLEMS WITH ANESTHESIA
☐	☐	MALIGNANT HYPERTHERMIA
☐	☐	TO TAKE ANTIOBIOTICS PRIOR TO DENTAL WORK OR SURGERY?

YES	NO	
☐	☐	KIDNEY DISEASE
☐	☐	LUNG BREATHING DISEASE
☐	☐	LUPUS OR MULTIPLE SCLEROSIS
☐	☐	PSYCHIATRIC DISORDER
☐	☐	PARKINSON'S DISEASE
☐	☐	RENAL FAILURE
☐	☐	RHEUMATOID ARTHRITIS
☐	☐	SKIN DISEASE
☐	☐	SLEEP APNEA AND USE OF CPAP

YES	NO	*DOES OR DID ANY BLOOD FAMILY MEMBER HAVE*
☐	☐	CANCER
☐	☐	DIABETES - ADULT ONSET
☐	☐	DIABETES - CHILDHOOD ONSET
☐	☐	GRAVES/THYROID DISEASE
☐	☐	HEART DISEASE
☐	☐	HIGH BLOOD PRESSURE
☐	☐	LUPUS OR MULTIPLE SCLEROSIS
☐	☐	PARKINSON'S DISEASE
☐	☐	OTHER_____

WHAT IS YOUR HEIGHT:_____ WHAT IS YOUR APPROXIMATE WEIGHT: _____

OTHER_____

HAVE YOU HAD ANY HEALTH-RELATED SURGERIES OR INJURIES (WHAT, WHEN) _____
_____
_____
_____

PATIENT:______________________________

ALLERGIES TO MEDICATIONS

____

____

____

CURRENT MEDICATIONS

Medication Name; Dosage & use (if known)	Reason Taking Med	FOR STAFF USE (Date & Initial)	 (Date & Initial)
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C