

Full Name _____
 Nickname _____
 Address _____
 City _____ State _____ Zip _____
 Date of Birth _____ Age _____ Sex: M F
 Employer/School _____
 Occupation/Grade _____
 Spouse (or Parent's) Name _____
 Children's Names & Ages _____
 SS# _____ Work Ph _____
 Home Ph _____ Cell Ph _____
 May we contact you by: _____ Home # _____ Office # _____
 _____ Cell# _____ Text _____ E-mail _____
 E-mail Address _____

Today's Date _____
 What is the primary purpose of today's visit? _____

 Last Vision Exam: _____
 Office/Doctor: _____

Current Medications (Rx or Over the counter)
 1. _____ 4. _____
 2. _____ 5. _____
 3. _____ 6. _____
Current Vitamins or Nutritional Supplements
 1. _____ 3. _____
 2. _____ 4. _____
Allergies to Medications? Y / N
 If so, please list:
 1. _____ 3. _____
 2. _____ 4. _____

IF YOU ARE A NEW PATIENT, PLEASE COMPLETE BELOW.

Personal and Family History (parent, grandparent, sibling, children) Please check any of the following for which you or a family member has a history. List relationship and specifics below.

	Self	Family		Self	Family
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Strabismus/Crossed Eye	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Amblyopia / Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disability / Dyslexia	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Autism/PPD	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Sensory Integration Issues	<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>

Other Medical Conditions _____
 Current State of Health Excellent Good Fair Poor

Do You...
 Currently wear glasses? Y N For: _____
 Currently wear contacts? Y N
 If so, what kind _____
 Replacement Schedule _____
Are You...
 Interested in wearing contacts? Y N
 Interested in Laser Vision Correction? Y N

Do You...
 Play Competitive Sports? Y N
 Type(s) _____
 Position(s) _____
 Work on the computer more than 4 hrs/day? Y N
 Perform other nearwork more than 4 hrs/day? Y N

Do you experience...

<input type="checkbox"/> Redness	<input type="checkbox"/> Headaches
<input type="checkbox"/> Spots / Floaters	<input type="checkbox"/> Nausea
<input type="checkbox"/> Flashes of light	<input type="checkbox"/> Dizziness / Imbalance
<input type="checkbox"/> Double vision	<input type="checkbox"/> Sensitivity to sounds
<input type="checkbox"/> Blurry distance vision	<input type="checkbox"/> Carsickness
<input type="checkbox"/> Blurry near vision	<input type="checkbox"/> Fatigue when reading
<input type="checkbox"/> Sudden loss of vision	<input type="checkbox"/> Inattentiveness
<input type="checkbox"/> Discomfort in Glasses	<input type="checkbox"/> Poor Night Vision
<input type="checkbox"/> Discomfort in Contacts	<input type="checkbox"/> Lack of coordination
<input type="checkbox"/> Glare or Reflection	<input type="checkbox"/> Difficulty after Car Accident
<input type="checkbox"/> Tearing / Burning	<input type="checkbox"/> Flicker Sensitivity
<input type="checkbox"/> Dryness	<input type="checkbox"/> Trouble walking up or down stairs
<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Light Sensitivity
<input type="checkbox"/> Soreness of eyes	<input type="checkbox"/> Other
<input type="checkbox"/> Tinnitus/Ears Ringing	
<input type="checkbox"/> Itchy Eyes	

How did you choose our office for your eye care?

Family / Friend Referral _____
 Professional Referral _____
 Insurance Provider List _____
 Advertisement In _____
 Website _____

Child's Developmental History

CHILD'S NAME _____ BIRTHDATE ___/___/___ AGE: _____
NICKNAME _____ HOME PHONE _____
FATHER'S NAME _____ DAYTIME PHONE _____
MOTHER'S NAME _____ DAYTIME PHONE _____
SIBLINGS NAMES AND AGES _____

DEVELOPMENTAL & BEHAVIORAL HISTORY

1. Full term pregnancy? _____ Normal birth? _____
2. Was there anything unusual about your child's early development? _____
3. At what age did your child first talk? _____
4. Any speech difficulties now? _____
5. First walked alone at what age? _____
6. Hand preference was clearly indicated at what age? _____ R or L or Both (please circle)
7. Are there any indications of hearing problems? _____
8. Have there been any significant injuries to your child's head or eyes? _____
9. Has a neurological, psychological, speech, or hearing evaluation been performed in the past?

TYPE OF EVALUATION DATE BY WHOM DIAGNOSIS

1. _____
2. _____
3. _____

ACADEMIC HISTORY

NAME OF SCHOOL _____ CURRENT GRADE _____

1. Does your child like school? _____ Like teacher? _____ Any grades repeated? _____
2. Have there been any school difficulties? _____
3. Child's favorite subjects? _____
4. Child's most difficult subject areas? _____

VISUAL SYMPTOMS AND OBSERVATIONS

	YES	NO
1. Vision is blurry at any time	_____	_____
2. Child sees double at any time	_____	_____
3. Complains of fatigue with reading	_____	_____
4. Confusion of similar words or letters	_____	_____
5. Reversals of words or letters when reading or writing	_____	_____
6. Poor comprehension	_____	_____
7. Dislikes reading but likes being read to	_____	_____
8. Rubs eyes during or after reading	_____	_____
9. Closes or covers one eye	_____	_____
10. Headaches when reading	_____	_____
11. Holds head too close to desk when writing	_____	_____
12. Difficulty copying from chalkboard or book	_____	_____
13. Neatness of writing is a problem	_____	_____
14. Slow with written work	_____	_____
15. Dislikes tasks requiring sustained visual concentration	_____	_____

NeuroSensory Center of Bellaire, P.A. – Patient Checklist

Today's Date: _____

Full Name _____ Birth Date ___ / ___ / ___ Age: _____

Neurosensory Checklist

Please circle the number in each box that is appropriate:

Difficulty	Never	Seldom	Sometimes	Frequently	Always	Comments
Allergies	0	1	2	3	4	
Anxiety	0	1	2	3	4	
Attention Difficulties	0	1	2	3	4	
Auditory Processing Issues	0	1	2	3	4	
Body Pain	0	1	2	3	4	
Coordination Problems	0	1	2	3	4	
Concentration Problems	0	1	2	3	4	
Depression	0	1	2	3	4	
Distractibility	0	1	2	3	4	
Dizziness	0	1	2	3	4	
Emotionality	0	1	2	3	4	
Fatigue	0	1	2	3	4	
Focus Challenges	0	1	2	3	4	
Headaches	0	1	2	3	4	
Hearing Problems	0	1	2	3	4	
Hyperacusis (Hearing Sensitivity)	0	1	2	3	4	
Imbalance / Balance Problems	0	1	2	3	4	
Impulsiveness	0	1	2	3	4	
Irritability / Mood Swings	0	1	2	3	4	
Memory Problems	0	1	2	3	4	
Physical Performance Issues	0	1	2	3	4	
Processing Difficulties	0	1	2	3	4	
Sleep Pattern Challenges	0	1	2	3	4	
Speech Difficulties	0	1	2	3	4	
Stimming	0	1	2	3	4	
Tinnitus (Ringing/Noise in Ear)	0	1	2	3	4	
Word Retrieval Issues	0	1	2	3	4	
School Performance Issues	0	1	2	3	4	

TOTAL SCORE =

Has there been a growth spurt / weight gain / loss recently? Yes No (please circle which choice if yes)

Vision Learning Center™ - Symptom Checklist

Today's Date: _____

Full Name _____ Birth Date ___ / ___ / ___ Age: _____

COVD-QOL Vision Checklist

Please circle the number that best represents the occurrence of each symptom and, if applicable, please complete with your child's input:

Symptoms	Never	Seldom	Sometimes	Frequently	Always
Blur when looking at near	0	1	2	3	4
Double vision, doubled or overlapping words on page	0	1	2	3	4
Headaches while or after doing near vision work	0	1	2	3	4
Words appear to run together when reading	0	1	2	3	4
Burning, itching or watery eyes	0	1	2	3	4
Falls asleep when reading	0	1	2	3	4
Seeing and visual work is worse at the end of the day	0	1	2	3	4
Skips or repeats lines while reading	0	1	2	3	4
Dizziness or nausea when doing near work	0	1	2	3	4
Head tilts or one eye is closed or covered when reading	0	1	2	3	4
Difficulty copying from the chalkboard	0	1	2	3	4
Avoids doing near vision work such as reading	0	1	2	3	4
Omits (drops out) small words while reading	0	1	2	3	4
Writes up or down hill	0	1	2	3	4
Misaligns digits or columns of numbers	0	1	2	3	4
Reading comprehension low, or declines as day wears on	0	1	2	3	4
Poor, inconsistent performance in sports	0	1	2	3	4
Holds books too close, leans too close to computer screen	0	1	2	3	4
Trouble keeping attention centered on reading	0	1	2	3	4
Difficulty completing assignments on time	0	1	2	3	4
First response is "I can't" before trying	0	1	2	3	4
Avoids sports and games	0	1	2	3	4
Poor hand/eye coordination, such as poor handwriting	0	1	2	3	4
Does not judge distances accurately	0	1	2	3	4
Clumsy, accident prone, knocks things over	0	1	2	3	4
Does not use or plan his/her time well	0	1	2	3	4
Does not count or make change well	0	1	2	3	4
Loses belongings and things	0	1	2	3	4
Car or motion sickness	0	1	2	3	4
Forgetful, poor memory	0	1	2	3	4

TOTAL SCORE =

List any other complaints your child makes concerning his/her vision: _____

Bellaire Family Eye Care

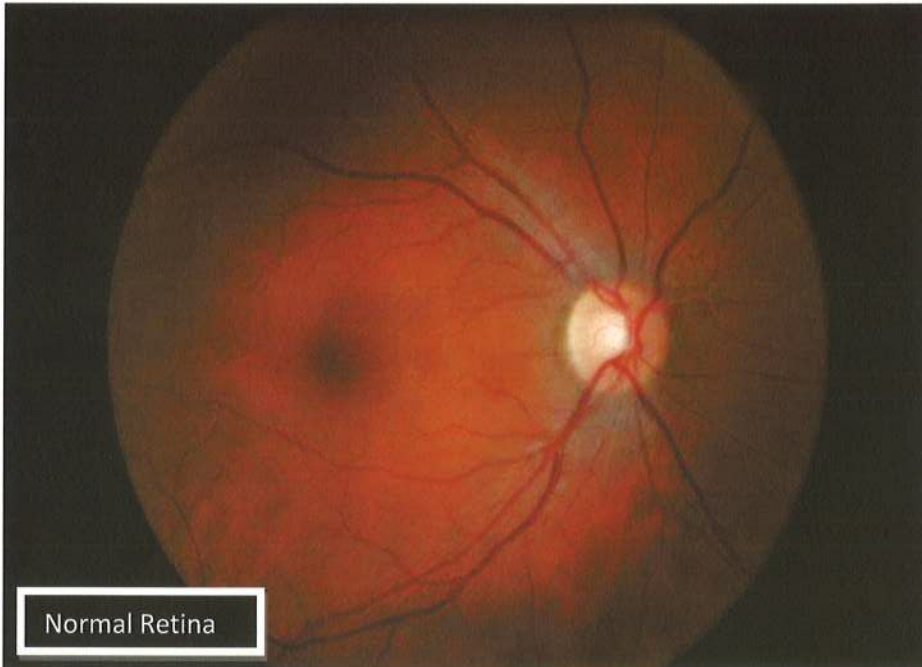
Photographic Retinal Examination

We at Bellaire Family Eye Care are pleased to provide our patients with an advanced digital photograph of your retina.

The Retinal Photographic Evaluation Includes:

- A copy of your retinal photo to take home
- An in depth view of the retinal surface
- A permanent record for your medical file, for serial analysis, comparisons, and diagnosis

Since insurance may not pay for this evaluation, this is an out of pocket expense. There is an additional cost of \$35.00 to the basic eye exam you are receiving today.



I AGREE TO have my retinal health evaluated with the Retinal Photographic Exam.

I DO NOT wish to have the Retinal Photographic Exam. I understand that I will still have a thorough eye examination with slit lamp observation.

Patient/Guardian's Signature

Date

**Bellaire Family Eye Care
Notice of Privacy Practices**

Our office is required by law to maintain the privacy of your health information and to provide you with this notice. It describes how your health information can be used and disclosed and how you can access this information.

We will only use and share your health information for the purpose of providing treatment for you and your family or obtaining payment. Your health information will not be used for any other purpose unless we have asked for and been given your written permission.

We promise to use your health information within our office to provide you with the best possible care. This may include office procedures designed to optimize the coordination of the care between the doctors, the technicians, and office staff. In addition, we may share information with referring physicians, pharmacies, and other health care professionals providing your treatment. We may share your information with a family member or friend who is involved in your medical care or payment for your care, provided that you agree to the disclosure, or we give you an opportunity to object to the disclosure.

Because we believe regular exams are crucial to maintaining the health of your eyes, we will send out reminders when its time to schedule an appointment. We may also contact you to follow up on your care and to inform you of new treatments or services that may be of interest to you and your family. These communications are an important part of our commitment to you and provide the best eye care possible.

Under the new HIPAA (Health Insurance Portability and Accountability Act) laws, patients have certain rights related to your health information. You have the right to restrict the uses and disclosure of your information. You have the right to request that we only communicate with you privately. You have the right to read, review, and copy your information. If you would like a copy of the right to complain to our office or to the Secretary of Health and Human Services, or if you believe your privacy have been compromised by this office, please express your request or concerns to us in writing.

Other than the procedures stated above, or where required by Federal, state, or local law, we will not disclose your health information without your written authorization. You may revoke that authorization in writing at any time.

Acknowledgment of Privacy Practices

I acknowledge that I have read and understand the privacy practices of this office.

Signed _____ Date _____

Bellaire Family Eye Care Financial Policy

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Payment is due at the time of service. For your convenience we accept VISA, Master Card, Discover, American Express or Debit Card.

Using Insurance for Services @ Bellaire Family Eye Care Suite

107: We have made prior arrangements with many insurers and other health plans. We will bill those plans with which we have an agreement and will collect any required co payment at the time of service. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. In that event we will bill you, and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not have a prior agreement, payment is due at time of service. We will provide you with a Super Bill for you to file.

Minor Patients: For all services provided to a minor, the adult accompanying the patient is responsible for payment.

Services from our Vision Learning Center Suite # 102:

Our Vision Learning Center (Suite #102) is a Self Pay Clinic. We do not file any insurances and payment is due at time of services.

Missed Appointments: In order to provide the best possible service and availability to all our patients, it is our policy to require 24 hour notice to cancel an appointment. At the time of cancellation you can go ahead and reschedule a make-up date.

I have read and understand the financial policy of Bellaire Family Eye Care and the Vision Learning Center and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature of Patient or Responsible Party if a Minor

Date

Signature of Co-responsible Party

Name of Patient: