Pediatric Ophthalmology Associates, Inc.

PATIENT INFORMATION

NAME (Last) (First) (Middle) (Preferred Name)	SEX ☐ Male ☐ Female	RACE	ETHNICITY	AGE	DATE OF BIRTH

ADDRESS (Street) (City) (State) (Zip)

HOME PHONE
CELL PHONE
MAY WE LEAVE A MESSAGE? Yes ☐ No ☐

EMAIL ADDRESS _____

BRIEFLY DESCRIBE THE PATIENT'S CHIEF COMPLAINT

IS ANOTHER FAMILY MEMBER SEEN HERE? (*NAME OF PATIENT AND NAME OF PHYSICIAN)*

PARENT INFORMATION

PARENT/LEGAL GUARDIAN (Last) (First) (Middle)	DOB	SS#
RELATIONSHIP TO PATIENT	OCCUPATION	WORK PHONE
GUARDIAN'S ADDRESS (IF DIFFERENT THAN PATIENT) (Street) (City) (State) (Zip)		HOME PHONE
PARENT/LEGAL GUARDIAN (Last) (First) (Middle)	DOB	SS#
RELATIONSHIP TO PATIENT	OCCUPATION	WORK PHONE
GUARDIAN'S ADDRESS (IF DIFFERENT THAN PATIENT) (Street) (City) (State) (Zip)		HOME PHONE

PHYSICIAN INFORMATION

FAMILY PHYSICIAN OR PEDIATRICIAN *(NAME, ADDRESS AND PHONE NUMBER)*

REFERRING PHYSICIAN *(NAME, SPECIALTY, ADDRESS AND PHONE)*

LIST ALL INSURANCE

INSURANCE COMPANY NAME AND ADDRESS

MEMBER NAME SUBSCRIBER NAME	MEMBER SS #	MEMBER DOB
MEMBER ID	EFFECTIVE DATE	

INSURANCE COMPANY NAME AND ADDRESS

MEMBER NAME SUBSCRIBER NAME	MEMBER SS #	MEMBER DOB
MEMBER ID	EFFECTIVE DATE	

Signature _____ Date _____

REVIEW OF SYSTEMS - PEDIATRICS

Patient name:_____ **MR#**_____ **Date**_____
REVIEW OF SYSTEMS: *please check any of the following symptoms your child is* **currently** *experiencing*

TOBACCO USE (for patients 13 and older only) ☐ Yes ☐ No

ALL NORMAL ☐ *Patient has none of the following issues:*

CHROMOSOME ABNORMALITIES
Chromosome Abnormality ☐
Chromosome Deletion ☐
Down's Syndrome ☐
Other _____

DEVELOPMENTAL
Appropriate for Age ☐
Developmental Delay ☐
Other:_____

GENERAL/CONSTITUTIONAL
Fever ☐
Weight Loss ☐
Weight Gain ☐
Fatigue ☐
Weakness ☐
Other:_____

INTEGUMENTARY (SKIN)
Rashes ☐
Dryness ☐
Sores ☐
Suspicious Growth ☐
Eczema ☐
Other:_____

EARS/NOSE/MOUTH/THROAT
Decreased Hearing ☐
Wears Hearing Aids ☐
Ringing in Ears (tinnitus) ☐
Nosebleeds ☐
Sinus Pain ☐
Sore Throat ☐
Other:_____

RESPIRATORY
Cough ☐
Shortness of Breath ☐
Wheezing ☐
Other:_____

CARDIOVASCULAR
Chest Pain and Discomfort ☐
Palpitations ☐
Murmur ☐
Other:_____

GASTROINTESTINAL
Nausea ☐
Vomiting ☐
Reflux ☐
Change in Appetite ☐
Constipation ☐
Diarrhea ☐
Feeding Tube ☐
Other:_____

GENITOURINARY
Blood in Urine ☐
Incontinence ☐
Sores ☐
Other:_____

MUSCULOSKELETAL
Muscle or Joint Pain ☐
Stiffness ☐
Swelling of Joints ☐
Hypotonia ☐
Weakness ☐
Paralysis ☐
Other:_____

NEUROLOGIC
Dizziness ☐
Fainting ☐
Seizures ☐
Weakness ☐
Numbness ☐
Tingling ☐
Tremor ☐
Decreased Memory ☐
Shunt Placement ☐
Tic ☐
Other:_____

PSYCHIATRIC
Anxiety ☐
Depression ☐
Stress ☐
Hyperactivity ☐
Distractibility ☐
Other:_____

ENDOCRINE
Heat or Cold Intolerance ☐
Sweating ☐
Poor Blood Sugar Control ☐
Growth Problem ☐
Other:_____

HEMATOLOGIC/LYMPHATIC
Easy Bruising ☐
Easy Bleeding ☐
Other:_____

PAST MEDICAL HISTORY (EVEN IF NO SYMPTOMS CURRENTLY)

ANY ADDITIONAL HEALTH INFORMATION FOR OUR DOCTORS

Preferred Pharmacy

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

REVIEWED MEDICAL HX DATED _____

DOCTOR'S INITALS: _____

GENERAL CONSENT

PEDIATRIC OPHTHALMOLOGY ASSOCIATES, INC.
555 S. 18TH ST. 4-C
Columbus, Ohio 43205
614 224-6222 614-241-5232 (fax)

Consent for Medical Treatment:
I and/or my parent(s) or guardian(s)* consent to let the doctors, technicians and employees of Pediatric Ophthalmology Associates**, Inc. do all things that may be necessary to diagnosis, treat and care for the needs of

_____
PATIENT'S NAME

(* From now on in this document, "I' will refer to: "I and my parent(s) or guardian(s).
(** From now on in this document the "Practice" will refer to Pediatric Ophthalmology Associates.)

Patient Rights and Responsibilities
I understand that I have the right to take part in decisions about my health care and plan for treatment.

Consent to Release Medical Information
I consent to let the Practice share/release information such as clinical, physical, mental, drug, alcohol, HIV or AIDS (including information that state and federal law and accreditation agencies require) to/with my doctors, my referring doctors or referring/referral healthcare provider; and to any insurance company or organization that helps pay my bill. The Practice may also give information to any welfare organization, to which I apply or may apply for aid.

Assignment of Insurance Benefits:
I consent to let the Practice bill my insurance companies, or other third party payor and allow those insurance companies or payors to pay the Practice directly for healthcare services provided. I understand that the insurance companies could send payment to me and I will be responsible for turning that money over to the Practice.

The Practice may ask Medicare or Medicaid to pay my bills if I am covered. Further, I confirm that the information given by me in applying for payment is correct.

Financial Responsibility:
I (or guarantor if appropriate) will pay all bills for my care including bills that insurance benefits do not pay.

Acknowledgement of Receipt of Privacy Practices:
I hereby acknowledge that I ☐ received ☐ declined a copy of the Notice of Privacy Practices of Pediatric Ophthalmology Associates which sets forth the ways that my protected health information may be used or disclosed by Pediatric Ophthalmology Associates, and outlines my rights with respect for such information.

I agree to allow this consent to be effective until I notify the Practice in writing that I want to change or revoke it.
AND
If there is a change in custody, I will notify the Practice at my next visit.

Signed_____
PARENT/GUARDIAN IF PATIENT IS LESS THAN 18 PATIENT IF 18 YEARS OR OLDER DATE

_____
PRINT NAME OF THE PERSON SIGNING RELATIONSHIP TO PATIENT

Signed_____
WITNESS DATE

PEDIATRIC OPHTHALMOLOGY ASSOCIATES, INC.

INSURANCE NOTICE

Our office is committed to making your visit a pleasant one. As a courtesy to you, we are happy to assist you with filing your insurance claims. To help you to understand our process, we have put together this summary of our billing policies.

Insurance Coverage

At each visit we will verify your address and phone number, update the medical history and verify your insurance coverage. Please bring the following to each visit:

- Copies of all Medical Insurance ID Cards
- Your Medical Insurance Copay
- Information on any Vision Plan Coverage

Referrals

Because the doctors are specialists, your insurance may require a referral. If a referral is not on file, your insurance may refuse to cover the service. Charges for services denied for lack of a referral will be billed to you.

Covered Services

Unfortunately, there are limits to insurance coverage. In some cases there are conditions or procedures that may not be covered by your insurance. These procedures may include:

- **ROUTINE OR PREVENTATIVE EYE EXAMS**
- **REFRACTIONS**
- **CONTACT LENS SERVICES**

If your insurance does not cover these services, you agree to be personally and fully responsible for payment.

I acknowledge that I have read and understand the billing policies of Pediatric Ophthalmology Associates.

Signature _____ Date _____