Judson Family Vision Care
Amanda Judson, OD, MS, FCOVD
Phone: 812-232-1000
Fax: 812-232-1007

INFANT / PRESCHOOLER

For Patients Infant through Pre-K

_____
Date of Visit

_____ _____
Patient Name (Last, First, MI) **Preferred Name / Nick Name**

_____ _____ _____ _____
Street Address **City** **State** **Zip Code**

_____ _____ _____
Home Phone **Cell Phone** **Email**

_____ _____ _____
Date of Birth **Age** **Social Security Number**

Gender : ☐ **Male** ☐ **Female** **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Other** _____

Insurance Information

Do you have Major Medical Insurance? ☐ **Yes** ☐ **No** **Do you have Vision Insurance?** ☐ **Yes** ☐ **No**

Name of Insurance Company: _____ **Name of Insurance Company:** _____

Policy Holder: _____ **Policy Holder Date of Birth :** _____

Employer: _____ **Policy Holder SSN:** _____

Please bring cards with you to appointment so they may be scanned into patient file. If you have more than one policy, please alert office when checking in. All co-pays and charges that are the responsibility of the patient are required to be paid on date of service.

Primary Care Physician / Pediatrician: _____

Phone Number: _____

If Patient is a minor please fill in the following: **Parent/Guardian Marital Status:** _____

_____ _____
Parent / Guardian Name **Relationship to Patient**

_____ _____
Parent / Guardian Name **Relationship to Patient**

_____ Patient Name _____ Reviewed

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Who may we thank for referring you to our office? _____

Why do you feel patient needs a Behavioral Vision Exam/Exam for Vision Therapy?

_____

VISUAL HISTORY

Date of last Eye Exam: _____ By Whom? _____ Were eyes Dilated? ☐ **Yes** ☐ **No**

Does patient currently wear glasses? ☐ **Yes** ☐ **No** Contact Lenses? ☐ **Yes** ☐ **No**

Please answer yes or no to the following Ocular conditions as they apply to the patient

Convergence Insufficiency	☐ **Yes** ☐ **No**	Eye Patching	☐ **Yes** ☐ **No**
Tracking Deficiencies	☐ **Yes** ☐ **No**	Retinopathy of Prematurity (ROP)	☐ **Yes** ☐ **No**
Visual Processing Deficiencies	☐ **Yes** ☐ **No**	Ocular Surgery	☐ **Yes** ☐ **No**
Visual Focusing Deficiencies	☐ **Yes** ☐ **No**	Retinal Detachment	☐ **Yes** ☐ **No**
Amblyopia (Lazy Eye)	☐ **Yes** ☐ **No**	Cataracts	☐ **Yes** ☐ **No**
Strabismus (Turned Eye)	☐ **Yes** ☐ **No**	Ocular Injury	☐ **Yes** ☐ **No**
Previous Vision Therapy	☐ **Yes** ☐ **No**	Chronic Eye Infections	☐ **Yes** ☐ **No**

Do any of the patient's family members (i.e. mother, father, siblings, grandparents) have problems with the previously listed conditions?
(Please list) _____

Has the patient experienced any significant Head Trauma? ☐ **Yes** ☐ **No** If yes, please explain: _____

_____

Date of last Eye Exam: _____ By Whom? _____ Were eyes Dilated? ☐ **Yes** ☐ **No**

Does patient currently wear glasses? ☐ **Yes** ☐ **No** Contact Lenses? ☐ **Yes** ☐ **No**

If patient has an eye turn, at what age was the eye turn first noticed? _____

Which direction does the eye turn? ☐ Up ☐ Down ☐ In ☐ Out Which eye turns? ☐ Right ☐ Left ☐ Both

Has there been any surgery? ☐ Yes ☐ No If yes, at what age? Which eye? Estimation of Results. _____

_____

Has patching been prescribed? ☐ **Yes** ☐ **No** If yes, please describe at what age patching was started, how it was done, the eye patched, for how long, and estimate of the results. _____

_____

Has vision therapy been prescribed? ☐ **Yes** ☐ **No** If yes, please describe duration of treatment, age at which it was started and estimate the results. _____

_____

Please Check Yes, No, or NA to the following observations and/or complaints as they relate to the patient

	Yes	No	N/A	If yes, when?
An eye turns in or out	☐	☐	☐	_____
Reddened or encrusted eyelids	☐	☐	☐	_____

_____ Patient Name _____ Reviewed

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VISUAL HISTORY CONTINUED

	Yes	No	N/A	If yes, when?
White appearance in the pupils	☐	☐	☐	_____
Seems visually unaware	☐	☐	☐	_____
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	☐	☐	☐	_____
Rubs eyes a lot	☐	☐	☐	_____
Covers or closes one eye	☐	☐	☐	_____
Stumbles over objects or is clumsy	☐	☐	☐	_____

Has the patient experienced any significant Head Trauma? ☐ **Yes** ☐ **No** If yes, please explain: _____

_____

DEVELOPMENTAL HISTORY

Patient is: ☐ **Biological** ☐ **Adopted** ☐ **Foster** ☐ **Other:** _____

Length of Pregnancy: _____ weeks Birth Weight _____ Mothers Age at Birth _____
Did Mother experience any health issues during the pregnancy? ☐ **Yes** ☐ **No** If Yes, Explain:

_____

_____

Type of Delivery: ☐ Vaginal ☐ Caesarian ☐ Forceps/Vacuum Was Anesthesia used? ☐ **Yes** ☐ **No**
Did patient experience any complications before, during, or immediately following delivery? ☐ **Yes** ☐ **No**
If Yes, Explain: _____

Did patient crawl/creep before walking? ☐ **Yes** ☐ **No** What age did patient start walking? _____

Did patient have any developmental delays? ☐ **Yes** ☐ **No** If yes, Explain: _____

_____

Has patient ever undergone any testing/treatment for the following?
Occupational ☐ **Yes** ☐ **No** Speech/Auditory ☐ **Yes** ☐ **No** Physical ☐ **Yes** ☐ **No**
If any were marked Yes, please explain: _____

_____

_____

What are your child's hobbies or favorite activities? _____

_____

_____ Patient Name _____ Reviewed

MEDICAL HISTORY

Has patient ever been diagnosed with ADD/ADHD? ☐ **Yes** ☐ **No**
If not diagnosed, has someone ever suggested possible ADD/ADHD? ☐ **Yes** ☐ **No** If Yes, who suggested this and why?

_____

Has patient ever been diagnosed with Autism? Aspergers,? PDD? PDD-NOS? ☐ **Yes** ☐ **No** If Yes, please explain:

_____

Has patient ever been diagnosed with Sensory Integration Issues? ☐ **Yes** ☐ **No** If Yes, please explain:

_____

Has patient ever been diagnosed with Auditory Processing Issues? ☐ **Yes** ☐ **No** If Yes, please explain:

_____

Is patient currently taking any medications (prescription or non-prescription)? ☐ **Yes** ☐ **No** If yes, Please list: _____

_____

Any Allergies to Medications? ☐ **Yes** ☐ **No** If yes, please list: _____

Any environmental allergies? ☐ **Yes** ☐ **No** If yes, please list: _____

Does the patient currently or ever have problems with any of these systems?

Gastrointestinal ☐ **Yes** ☐ **No**
(Ulcer, Liver Disease, Gallbladder)

Ear/Nose Throat ☐ **Yes** ☐ **No**
(Hearing problems, Sinus Disease, Tubes)

Endocrine ☐ **Yes** ☐ **No**
(Thyroid Disease, Pituitary Disease)

Diabetes ☐ **Yes** ☐ **No**
(Type 1, Type 2)

Cardiovascular ☐ **Yes** ☐ **No**
(Blood pressure, Heart Disease)

Blood / Lymph ☐ **Yes** ☐ **No**
(Anemia, Bleeding Disorder)

Skin Disorder ☐ **Yes** ☐ **No**
(Rashes, Eczema, Psoriasis)

Nervous System ☐ **Yes** ☐ **No**
(Seizures, Headaches, Multiple Sclerosis)

Genitourinary ☐ **Yes** ☐ **No**
(Kidney Disease, Bladder Disease)

Mental Health ☐ **Yes** ☐ **No**
(Depression, Anxiety, Alzheimer's)

Musculoskeletal ☐ **Yes** ☐ **No**
(Arthritis, Osteoporosis)

Respiratory ☐ **Yes** ☐ **No**
(Asthma, Emphysema, COPD)

Allergic/Immune ☐ **Yes** ☐ **No**
(Autoimmune Disease, HIV, Allergic Status)

Cancer ☐ **Yes** ☐ **No**

Please explain any Health Conditions marked yes: _____

_____

_____

Do any of the patient's family members (i.e. mother, father, siblings, grandparents) have problems with the above conditions? (Please list) _____

_____

Please list any major illnesses, surgeries, or long-term hospitalizations: _____

_____

HIPPA

I acknowledge that I have had the opportunity to review Dr. Amanda Judson's Notice of Privacy Practices and have been given a copy of the Notice if I requested it.

Patient Signature or Legal Guardian_____Date_____

_____ Patient Name

_____ Reviewed

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FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service. We 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.

Please read and initial each item below that you have read and agree to the following payment terms regarding all services and materials provided by Judson Family Vision Care (JFVC).

_____ 1. I agree to provide a copy of all of my insurance cards and any necessary information to enable JFVC to be able to submit insurance claims for my care at JFVC.

_____ 2. I understand that I am responsible for payment of my account regardless of insurance coverage or eligibility.

_____ 3. I authorize the release of any medical information necessary to process all claims.

_____ 4. I understand that after my insurance company has been billed, I am responsible for payment on my account for any non-covered items or services.

_____ 5. I understand that I am responsible for all co-pays for my care and that those co-pays are due at the time that services are rendered.

_____ 6. I understand that payment is due at the time of service. I understand the methods of payment accepted by JFVC are Cash, Check, VISA, Master Card, Discover, or Debit Card.

_____ 7. I understand that I am responsible for payment of my account regardless of insurance coverage or eligibility.

_____ 8. I understand that any check returned to JFVC for non-sufficient funds will be subject to a $50.00 fee. I agree to pay this fee in addition to any collection and/or attorney fees incurred in collecting the dishonored check.

_____ 9. I understand that any outstanding amount will be due and payable within 30 days after JFVC has received written notice from my insurance company that a claim has been denied or partially paid. If insurance company pays for these charges after appealing any claim decision, JFVC will reimburse patient for covered charges.

_____ 10. I understand that any account balance over 120 days will be turned over to a collection agency or attorney for collection. I will be responsible for all fees incurred in collecting this debt.

_____ 11. I understand that I will be charged a $50.00 non-refundable fee if I fail to notify the office 24 hours in advance when a scheduled appointment must be cancelled or rescheduled.

_____ 12. I understand that if I am insured by Medicaid and have any spend down that has not been met that I will be responsible for that portion. This is not determined until after JFVC has filed a claim and received notice from Medicaid. I understand that I will be responsible for any amount shown on the Explanation of Benefits and agree to pay this within 30 days of JFVC receiving this notice.

_____ 13. I hereby authorize payment of insurance benefits to be made directly to Judson Family Vision Care for any services or materials provided to me or designated patient as furnished by this supplier. This assignment will remain in effect until revoked by me in writing.

_____ 14. I agree that I will give JFVC copies of all insurance cards and that if I have multiple insurances, that if I am sent the EOB from the first insurance that I will give JFVC a copy of that EOB so that a claim can be submitted to my secondary insurance. If I refuse to give a copy of all insurance cards and /or copy of EOBs which results in JFVC not being able to submit for coverage to its fullest, I understand that I will be financially responsible for the remaining charges.

I have read, understood and agreed to the financial policy of Judson Family Vision Care.

_____ _____

Patient Name Signature of Responsible Party Date

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HIPPA INFORMATION RELEASE FORM

At Judson Family Vision Care, we take the privacy of your health information seriously. We will not release a patient's health information outside of the allowed exceptions spelled out in our Notice of Privacy Practices without your verbal or written permission.

This form gives you the opportunity to tell us whom we can speak to regarding your health information. You are not required to list anyone, and you can change whom we are permitted to speak to at any time by completing a new form.

I authorize Judson Family Vision Care physicians and/or staff to speak to the individuals listed below regarding my health and billing information. I understand that I can revoke this authorization at any time by completing a new form.

_____ _____

Patient Printed Name Date of Birth

Name	Relationship
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

_____ _____

Signature Date

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