MT. JULIET FAMILY VISION CENTER

DATE_____

PEDIATRIC HISTORY QUESTIONNAIRE **PATIENT INFORMATION** **PLEASE PRINT**

NAME:_____NAME YOU PREFER TO BE CALLED_____

ADDRESS_____CITY_____ST_____ZIP_____

HOME PHONE_____WORK _____CELL_____

SOC. SEC #_____BIRTHDATE_____AGE_____ SEX: M F

PERSON RESPONSIBLE FOR THIS ACCOUNT_____RELATIONSHIP TO PATIENT_____

IN CASE OF EMERGENCY, CONTACT_____PHONE_____

INSURANCE INFORMATION

MAJOR MEDICAL INSURANCE INFORMATION

POLICYHOLDERS NAME_____RELATIONSHIP TO PATIENT_____

BIRTHDATE_____SOC. SEC #_____

EMPLOYER_____PHONE_____

INSURANCE COMPANY_____ID NUMBER_____

IS PATIENT COVERED BY ADDITIONAL INSURANCE? Y N INSURED'S NAME_____

BIRTHDATE_____SOC. SEC#_____RELATIONSHIP TO PATIENT_____

INSURANCE COMPANY_____ID NUMBER_____

VISION INSURANCE INFORMATION

POLICYHOLDERS NAME_____RELATIONSHIP TO PATIENT_____

BIRTHDATE_____SOC. SEC #_____

PLEASE CIRCLE IF YOU HAVE ANY OF THE FOLLOWING: VSP VCP CIGNA VISION BLUECROSS/BLUESHIELD

MEDICAL HISTORY

REASON FOR YOUR VISIT TODAY (indicate any specific vision problem or symptom)_____

ARE YOU INTERESTED IN CONTACT LENSES? Y N

DATE OF LAST EYE EXAMINATION_____LAST EYE DOCTOR_____

RESULTS OF LAST EYE EXAMINATION_____

NAME OF PEDIATRICIAN/DOCTOR_____DATE OF LAST PHYSICAL/DOCTORS VISIT_____

MEDICATIONS

LIST ALL CURRENT MEDICATIONS AND THE CONDITIONS THEY ARE FOR:_____

_____

_____

ANY ALLERGIES OR KNOWN MEDICINE ALLERGIES?_____

LIST ANY MEDICINES CHILD HAS TAKEN FOR A LONG PERIOD OF TIME?_____

SOCIAL HISTORY

NAME OF SCHOOL_____GRADE_____TEACHER_____

COMMENTS/CONCERNS ON SCHOOL PERFORMANCE_____

FULL TERM PREGNANCY?____NORMAL BIRTH?_____COMPLICATIONS/DEVELOPMENTAL DELAYS_____

PERSONAL & FAMILY HISTORY

HAVE YOU OR ANY FAMILY MEMBER EVER HAD ANY OF THE FOLLOWING DISEASES/CONDITIONS?

X=SELF M=MOTHER F=FATHER B=BROTHER S=SISTER GF=GRANDFATHER GM=GRANDMOTHER

___DIABETES	___THYROID PROBLEMS	___MULTIPLE SCLEROSIS	___MACULAR DEGENERATION	___EMOTIONAL PROBLEMS
___HIGH BLOOD PRESSURE	___KIDNEY PROBLEMS	___EYE INJURY/SURGERY	___LAZY EYE/CROSSSED EYES	___SINUS PROBLEMS
___HIGH CHOLESTEROL	___LIVER PROBLEMS	___GLAUCOMA	___VISION THERAPY	___MIGRAINES
___STROKE	___EPILEPSY	___CATARACTS	___ASTHMA	___HEAD INJURY/SURGERY
___HEART DISEASE	___CANCER	___RETINA DISEASE	___DIFFICULTY BREATHING	___NECK INJURY/SURGERY

FOR DOCTOR'S USE:

Reviewed:___/___/___ PD/MD Reviewed___/___/___ PD/MD Reviewed ___/___/___ PD/MD Reviewed___/___/___PD/MD 08/09

FINANCIAL & INSURANCE AUTHORIZATION

HIPAA CONSENT

PATIENT NAME **DATE**

AUTHORIZATION

I hereby give my consent to the doctors, staff and associates of Mt. Juliet Family Vision Center to provide eye care services to myself and/or family. I understand and agree (regardless of my insurance status) that I am responsible for the balance of the account.

RESPONSIBLE PARTY SIGNATURE_____**DATE**_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Mt. Juliet Family Vision Center all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

RESPONSIBLE PARTY SIGNATURE_____**DATE**_____

INSURANCE POLICY

Changes made daily among insurance companies, make it impossible for us to accept the responsibility of knowing if your plan dictates benefits, payment, coverage and whom you can and cannot see. As a service to you, we will file your insurance claim. In order for us to file your insurance, please provide all insurance information on the day of your visit. **It remains the responsibility of the patient to know his or her own plan.** As a service to you, we will call your insurance company for an estimate of what they will pay. It is important to know that any information given over the phone cannot be guaranteed and is only an **estimate**. The day of your exam, we require you pay your estimated difference between insurance payments and the provider charges.

RESPONSIBLE PARTY SIGNATURE_____**DATE**_____

MEDICARE AUTHORIZATION (if patient has Medicare)

I request that payment of authorized Medicare benefits be made on my behalf to Mt. Juliet Family Vision Center for services furnished to me by Mt. Juliet Family Vision Center. I authorize any holder of medical information about me to release to the Division of Medicare and Medicaid Services and it agents any information needed to determine those benefits payable for related services. I understand that my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 on the HCFA-1500, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

BENEFICIARY SIGNTURE_____**DATE**_____

HIPAA CONSENT

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Mt. Juliet Family Vision Center may condition treatment upon the execution of this consent.

Additionally, by signing this form, you acknowledge that by presenting yourself as a patient or child you consent for vision and medical care by Dr. Davis and the staff of Mt. Juliet Family Vision Center. You hereby grant full authority to Dr. Davis and respective assistants to administer and perform any and all drugs, treatments, test, or diagnostic procedures to or upon you, which may be advised, or necessary.

All health information may be shared with_____ RELATIONSHIP_____

PATIENT_____ **DATE**_____

SIGNED BY_____ **RELATIONSHIP (if other than patient)**_____

WITNESS_____

Mt. Juliet Family Vision Center Representative