Children's Eyes Albany
Medical History

Name: _____DOB: _____Acct #_____ Date: _____

Referring Physician Name & City: **Primary Physician Name & City:**

Other Health Care Provider(s):

Pharmacy Name & Address:

Current Meds Name, Dosage and Frequency:

No Known Drug Allergies Drug Allergies Drug & Reaction:

Medical History: List any major illnesses, hospitalizations, injuries or surgery

1. 2. 3. 4. 5.

6. 7. 8. 9. 10.

Family History: None Eye Additional

Birth History: Premature? Yes No Number of weeks pregnant at delivery? _____ Birth Weight_____

Social History: What family members live at home with the patient? _____

Custodial Parent/Guardian: _____

Developmental History: None Growth Delay Motor delays/weakness Reading/Academic PT ST OT Special Ed.

Do you CURRENTLY have any of the following? If yes, please circle:

_____Decreased Vision _____Headache _____Weight Loss _____Fever _____ Muscle Weakness

_____Numbness _____Nervousness _____Memory Loss _____Chest Pain _____Shortness of Breath

_____Nosebleed _____Sinus Problems _____Skin Reactions _____Trouble Swallowing

_____Diarrhea _____Trouble urinating _____Nasal/Postnasal Discharge _____ Other (Describe): _____
_____

For Office Use Only:

History Reviewed by: _____ & _____ with _____Date:_____

Children's Eyes Albany

Patient Information:

Name: _____ DOB: _____

Sex: Male/Female Height: _____ Weight: _____ Best Contact # (____) ____-____

Mailing Address: _____

City_____ State_____ Zip Code_____ Alt. Contact # (____) ____-____

Parent/Guardian/Other:

Name: _____ DOB: _____

Relationship to patient: _____ Email: _____

Pediatrician/Family Doctor Information:

Name: _____ Phone (____) ____-____ Fax (____) ____-____

Address: _____

Pharmacy Information:

Name: _____ Phone (____) ____-____ Fax (____) ____-____

Address: _____

Insurance Information:

Primary: Subscriber Name: _____ DOB: _____

Insurance Company Name: _____ ID: _____

Secondary: Subscriber Name: _____ DOB: _____

Insurance Company Name: _____ ID: _____

Reviewed by: _____

Children's Eyes Albany

920 Albany Shaker Rd. Suite 101
Latham, NY 12110

Dilation

Dilating the pupils with eye drops allows the doctor the best view of the internal structures of the eye and is considered the standard of care in new patients. The drops also permit the use of a technique which enables the doctor to prescribe glasses for pre-verbal children and can be useful in other situations where an accurate refraction might otherwise be difficult. This too is considered the "Gold Standard" when prescribing glasses for children and young adults. The drops, which are not painful, take 30 minutes to work properly, during which your child may play in the waiting room. Children who have had dilating drops may notice difficulty focusing on near objects and may be more sensitive to bright sunlight. These effects start to wear off after several hours, but may persist for longer, especially in individuals with light colored eyes. We understand that most children and many adults do not like eye drops. However, we are unable to provide the highest quality of care without their use and appreciate your understanding.

Refraction

Refraction is the measurement of the lens prescription required to give the best possible vision in each eye. It is an essential part of many eye exams, even in patients who appear to see well, and especially during childhood. However, Medicare and most commercial insurance plans have elected not to cover the cost of refraction and insist the $25.00 charge be billed separately.

Sensory Motor Examination

The sensory motor exam is comprised of a battery of tests which evaluate a patient's binocular cooperation and ocular alignment. It may be required in addition to those tests performed during a normal eye exam, especially in complex cases, such as those involving double vision (diplopia) and/or a horizontal or vertical misalignment of the eyes. Information from the sensory motor exam is then used to plan the best optical, medical and surgical treatment. This procedure is billed separately from the overall examination and is subject to additional fees (co-payments/deductibles).

No Shows

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences. Due to high patient demand, and limited availability of appointments we have instituted a $50 no show fee. You must give 24-hour advanced notice to cancel appointments. Failure to do so will result in a $50 fee charged to your account.

Participation, Pre-Authorization, Referrals

I understand that I am responsible for contacting my insurance carrier(s) to confirm if the doctor you are seeing at CEA is participating with my insurance carrier(s) and that I am eligible for benefits on or before the date my visit(s) take place. Furthermore, I agree to contact my insurance carrier(s) and/or Primary Care Physician to determine if it is necessary to obtain any pre-authorization/ referral before my visit(s) take place. Moreover, I agree to pay for any dollar amount denied or applied to my deductible by my insurance carrier(s), due to the fact that I failed to present a pre-authorization/ referral at the time of my visit.

By signing below, I acknowledge that I have read and understand the information and policies above.

Patient Name: _____ Parent/Guardian Name & Relationship_____

Patient/Parent/Guardian Signature: _____Date: _____

Children's Eyes Albany

920 Albany Shaker Rd. Suite 101
Latham, New York 12110
(518) 533-6502-P (518) 533-6505-F

Patient Name:_____ Date of Birth:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my Protected Health Information (PHI). I understand I may request in writing that you restrict how my PHI is used and disclosed to carry out treatment, payment or healthcare operations.

PATIENT AUTHORIZATION FORM

This authorization permits Children's Eyes Albany to ***contact me and/or leave messages regarding appointments and/or protected health information*** in the following ways:

Please check all that apply

Appointment Information	**Health Information**
_____Phone	_____Phone
_____with another person	_____with another person
_____Send Via Mail	_____Send via Mail
_____Email	_____Email

List of persons we are authorized to discuss your protected health information with:

Name: _____ Relationship:_____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

This authorization will remain in effect from the date signed below indefinitely unless I notify this office in writing. My revocation will be submitted to Children's Eyes Albany at the above address.

Print Name: _____

Relationship to patient: _____

Signature: X _____ Date: _____