HEARTLAND
EYE CONSULTANTS

9900 Nicholas Street ○ Suite 250 ○ Omaha, NE 68114
402-493-6500 ○ 888-837-3937 (EYES) ○ **Fax: 402-493-4370**

To Our Valued Patient:

Thank you for choosing Heartland Eye Consultants! We are looking forward to seeing you for your appointment. Enclosed you will find a location map and a couple of forms. We would greatly appreciate your taking the time to fill out these forms at home. This will save valuable time in-office and make available more time with your doctor. You may mail or fax them back to us or bring them with you to your appointment, if there is not sufficient time for mailing.

Your appointment is on _______________________ at __________AM PM.

Please bring the following with you to your appointment:

1. The enclosed Patient Information Forms
2. The History form
3. Your insurance card
4. Your co-pay
5. A list of any medications you take with the dosages
6. Your glasses

Please note that all co-payments and applicable yearly deductibles are due at the time of your visit. Please make sure you have a credit card, your check book or cash with you.

This examination will NOT be considered a ROUTINE visit so we will be using your major medical insurance, not your 'eye' or 'eye glasses' insurance.

If your insurance requires a referral from your primary care doctor (pediatrician or family doctor, *not* your eye doctor), it is your responsibility to request the referral **before** your appointment at Heartland Eye Consultants. If that is not done **by you** ahead of time, we may have to reschedule your appointment because some doctor's require a day's notice or more to get those completed and faxed to us.

Handicapped Parking and Senior Parking is available on the **west** side of the building. Parking there will eliminate the need to climb stairs.

If you have any questions or need to reschedule your appointment, please call us at (402)493-6500 or 888-837-3937. Thank you for entrusting your vision to us!

Sincerely,

Patient Services

Heartland Eye Consultants
Adult Patient Demographics

Patient:

Last Name:___________________________ First Name:_______________________ M.I.____
Street Address:________________________Apt #_____ Gender: M F Date of Birth:___/___/______
City: ___________________ State:_____ Zip Code:_______ Soc. Sec. No. ____-____-_______

When we contact you to confirm or change an appointment, which method(s) do you prefer? (Please place an X in the circles.)

○Call ○Text Cell Phone: (___)____________ ○Home Phone:(____)__________

○Work Phone:(____)__________ ○Email Address: ___________________

Occupation:______________________Employer:______________________
Employer's Address:______________________ City, State, Zip: ___________________________
Is this visit a result of an accident or illness *that occurred at work*? Yes No
Which doctor referred you to our office?____________________ If not, please list _______________
Who performed your last eye exam? _______________________ Date:____/____/__
Pediatrician/Family Physician: ____________________
Name of Emergency Contact:____________________ Relationship:____________Phone:__________
(Not living in household) (Area Code)

If the patient is married, please complete spouse information:

Spouse's Last Name:_________________First Name:__________ M.I.____ Birthdate: ____/____/_____
Cell Phone: ____________ Home Phone:____________ Email Address: ______________________
SSN:_______________ Employer: ____________ Occupation______________Title: __________
Employer's Address:_________________________ City________________ State_____Zip______

The person requesting services is the responsible party.

We will file major medical insurance coverage for you if you provide us with a copy of your current card.
For patients without insurance coverage, you will be responsible for payment. Please indicate your preferred method of payment:
Cash Check Credit Card (Mastercard/Visa)

Photo Release:
I hereby grant Heartland Eye Consultants, L.L.C. and Developmental Vision Associates, P.C. permission to have my photograph taken for patient information. This does not allow them to use my likeness in photographs and/or video in any of its publications or media.

AUTHORIZATION TO RELEASE INFORMATION TO YOU INSURANCE COMPANY AND ACKNOWLEDGEMENT OF PERSONAL RESPONSIBILITY FOR PAYMENT

I hereby assign all medical benefits (to which I am entitled) to the doctor caring for me. This includes major medical benefits, Medicare, Medicaid, private insurance and any health plans in which I am enrolled. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize the holder of my medical and patient registration records to release any information need to process my insurance claims. I understand that I am the guarantor of this account.

A copy of my medical records can be requested in writing and will be provided to me or whomever I designate for $15.00. There is a $25.00 fee for returned checks.

Authorized Signature: ________________________________Date of Signature: ____________

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CANCELLATION POLICY

Patient Name: ______________________________

If patient is a minor, Parent Name: _____________________________

In today's hectic world unplanned issues come up for all of us. We recognize this fact, but we respectfully request that if you need to cancel your appointment with us that you call at least **24 hours prior to your appointment.** With your prompt cancellation, we will be able to schedule another patient in need of an appointment.

If you cancel, reschedule, or miss your scheduled appointment **without** 24 hours notice, the first time will be excused. However, if you miss a second appointment you will be responsible to pay a **$50.00** fee. If a third appointment is missed, a **$100.00** fee will be charged. This fee is **not** covered by insurance carriers, Medicare or Medicaid and will be your responsibility to pay before rescheduling.

I understand the above Cancellation Policy implemented by Heartland Eye Consultants.

______________________________ ________________
Patient/Parent Signature Date

______________________________ ________________
HEC Employee Witness Date

Heartland Eye Consultants, LLC
9900 Nicholas Street, Omaha, NE 68114 (402)493-6500 Fax: (402)493-4370

ADULT STRABISMUS HISTORY

Please fill out this questionnaire carefully. Please mail or fax this form to us or bring it with you to your appointment. Thank you!

First Appointment: ______________________________
Day Date Time

GENERAL INFORMATION

FULL NAME______________________________DOB____/____/______AGE ______ ☐ Male ☐ Female

YOUR VISUAL HISTORY:

At what age was it first noticed *or suspected* that an eye was turning? ______________________________

Was there trauma/disease that preceded or accompanied the onset of the eye turn? ☐ Yes ☐ No

If yes, please explain: ______________________________

Did the eye begin turning ☐ suddenly? ☐ gradually?

Does the eye turn ☐ in? ☐ out? ☐ up? ☐ down? (Check all that apply)

Is the eye turn getting ☐ worse? ☐better? or is there ☐ no change?

Is it always the same eye that turns? ☐ Yes ☐ No

If yes, which eye? ☐ Right ☐ Left

Is the eye turn always present? ☐Yes ☐ No

If no, under what conditions is it present? (I.e. when tired, ill, etc.) ______________________________

Does the eye always turn the same amount? ☐ Yes ☐ No

If no, explain: ______________________________

Do you notice if the eye turns more when you look:

at objects up close? ☐Yes ☐ No
at objects in the distance? ☐Yes ☐ No
to your left? ☐ Yes ☐ No
to your right? ☐Yes ☐ No
up? ☐Yes ☐ No
down? ☐Yes ☐ No

Does one pupil ever appear to be larger than the other? Yes ☐ No ☐

Do you ever notice one or both eyes shaking rapidly? Yes ☐ No ☐

Do you notice any of the following?

	Yes	No	If yes, when?
Headaches	☐	☐	____________
Blurred vision	☐	☐	____________
Double vision	☐	☐	____________
Eyes tired	☐	☐	____________
Eyes hurt	☐	☐	____________
Motion sickness / car sickness	☐	☐	____________
Frequent sties	☐	☐	____________
Red or bloodshot eyes	☐	☐	____________
Watery eyes	☐	☐	____________
Bothered by light	☐	☐	____________
Closing or covering an eye to see better	☐	☐	____________
Need to hold paper close when reading or writing	☐	☐	____________
Head tilt	☐	☐	____________
Confusion of letters or words	☐	☐	____________
Skipping or omitting words	☐	☐	____________

Date of Completion________

	Yes	No	If yes, when?
Loss of place when reading	☐	☐	____
Need to use finger to keep place	☐	☐	____
Poor reading comprehension	☐	☐	____
Comprehension decreases over time	☐	☐	____
Write or print poorly	☐	☐	____
Fatigue easily	☐	☐	____
Difficulty with short term memory	☐	☐	____
Difficulty with long term memory	☐	☐	____
Short attention span / loss of interest	☐	☐	____
Difficulty attending to details	☐	☐	____
Poor / awkward general motor coordination	☐	☐	____
Poor fine motor coordination	☐	☐	____
Difficulty judging distances	☐	☐	____
Difficulty driving	☐	☐	____
Dislike / avoid sports	☐	☐	____
Difficulty hitting or judging moving targets during sports	☐	☐	____

List any other complaints you have concerning vision: ________________________________

____

Do you believe your vision hampers your daily activities in any way? Yes ☐ No ☐

If yes, explain: ________________________________

Do you believe your vision limits your potential in any way? Yes ☐ No ☐

If yes, explain: ________________________________

YOUR PREVIOUS TREATMENTS

Have you had a previous visual evaluation? ☐ Yes ☐ No

If yes, Doctor's Name: ________________________ Date of last evaluation: ____________

Results and recommendations: ________________________________

Were glasses, contact lenses, or other optical devices recommended or prescribed? ☐ Yes ☐ No

If yes, bifocal? ☐ Single vision? ☐ Contact lenses? ☐ Other? ☐ Explain: .... ________

Are they worn? Yes ☐ No ☐

If yes, when? ________________________________

If no, why not? ________________________________

Does the eye turn less when the prescription is worn? ☐ Yes ☐ No ☐ Unsure

Have you been told that you have amblyopia (lazy eye)? ☐ Yes ☐ No

Has there been any treatment using an eye patch? ☐ Yes ☐ No

If yes, please describe when the patching was started, how the patching was done, including the age it started, the eye patched, the duration of treatment, and an estimate of the results: ____________

____

____

Has there been any surgical treatment? ☐ Yes ☐ No

If yes, please describe the surgery, including the age surgery was performed, the number of operations, the eye(s) operated on, and an estimate of the cosmetic and subjective results: ____________

____

____

Was the surgeon satisfied with the results of surgery? ☐ Yes ☐ No Explain: ____________________

____

Were you satisfied with the results of surgery? ☐ Yes ☐ No Explain: ____________________

Have surgical results been maintained? ☐ Yes ☐ No Explain: ____________________

Has there been any visual therapy? ☐ Yes ☐ No

If yes, Doctor's name: ____________________

Please describe the type of visual therapy, including duration, the age at which it started and an estimate of results: ____________________

Are you here for a second opinion regarding surgery or other treatment? ☐ Yes ☐ No

YOUR DEVELOPMENTAL HISTORY

Full-term pregnancy? ☐ Yes ☐ No

Did your mother experience any problems during the pregnancy with you? ☐ Yes ☐ No

If yes, explain: ____________________

Normal birth? ☐ Yes ☐ No

If No, explain: ____________________

Were forceps used? ☐ Yes ☐ No

Any complications before, during or immediately following delivery? ☐ Yes ☐ No

If yes, explain: ____________________

Were there ever any concerns regarding growth or development? ☐ Yes ☐ No

If yes, explain: ____________________

YOUR EMPLOYMENT/SCHOOL

Current position: ____________________ Major course of study: ____________________

How many hours daily do you spend at a desk? ________

How many hours daily do you spend reading or studying? ________

How many hours daily do you spend working at near distances? ____________________

Are you achieving your potential in work or school? ☐ Yes ☐ No

Do you believe you are getting adequate return for the amount of effort you put into a task? ☐ Yes ☐ No

Does your work or course of study demand comprehension of written word? ☐ Yes ☐ No

Describe briefly your daily activities at work or in school: ____________________

YOUR HOBBIES/LEISURE TIME

Describe the types of activities that comprise the majority of your spare time: ____________________

Do you watch TV? ☐ Yes ☐ No

If yes, how many hours per day? ________ How many days per week? ________

Are you seriously involved with athletics? ☐ Yes ☐ No

Do you believe you are achieving your potential in athletics? ☐ Yes ☐ No

Of all the sports you have played:

List the ones in which you excel: ____________________

List the ones in which you do poorly / avoid: ____________________

Do you believe your vision limits or prevents you from participating in any activities? ☐ Yes ☐ No

If yes, explain: ____________________

PERSONAL AND FAMILY MEDICAL HISTORY

Are there any problems with any of the following? (Please check if there is a history)

	You	Family	Who?		You	Family	Who?
Diabetes	___	___	__________	High Blood Pressure	___	___	__________
Glaucoma	___	___	__________	Cataracts	___	___	__________
Thyroid Disease	___	___	__________	Heart Disease	___	___	__________
Blood Disorder	___	___	__________	Hormone Disorder	___	___	__________
Multiple Sclerosis	___	___	__________	Allergies	___	___	__________
Breathing	___	___	__________	Stomach/Intestines	___	___	__________
Ears/Nose/Mouth	___	___	__________	Blindness	___	___	__________
Amblyopia	___	___	__________	Strabismus	___	___	__________
Brain Tumor	___	___	__________	Cancer	___	___	__________

Physician's Name:______________________________ Date of Last Evaluation: ____________________

For what problem / condition? ____

Results and recommendations: ____

Medications currently using including vitamins and supplements: ______________________

For what condition(s)? ____

Are you allergic to any foods or medications? ☐ Yes ☐ No

If yes, please list: ____

Current state of health (explain): ____

____

Any history in your family of an eye turn resulting from a disease or other condition? ☐ Yes ☐ No

If yes, please explain: Who?____

Are you prone to infections? ☐ Yes ☐ No

Are there any chronic problems like ear infections, asthma, hay fever, allergies? ☐ Yes ☐ No

If yes, please list: ____

List illnesses, bad falls, high fevers, ear infections, etc.:

Age	Severe	Mild	Complications

Have you had a neurological evaluation? ☐ Yes ☐ No

By whom? ________________________ Results: ______________________________

____

Have you had a psychological evaluation? ☐ Yes ☐ No

By whom? ________________________ Results: ______________________________

____

Have you had an occupational therapy evaluation? ☐ Yes ☐ No

By whom? ________________________Results:______________________________

Is there any other information that you believe would be helpful to the doctor for your evaluation/treatment?

☐ Yes ☐ No If yes, explain: ____

____

____________________________________ ________________

Signature of Patient or Guardian Date