

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  
Pediatric 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. \_\_\_-\_\_\_-\_\_\_ **Age** \_\_\_\_\_

Which doctor referred you to our office? \_\_\_\_\_ If not, please list \_\_\_\_\_

Who performed your last eye exam? \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Pediatrician/Family Physician: \_\_\_\_\_ M.D.

Name of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
(Not living in household) (Area Code)

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**Please place an X in the boxes to indicate with whom the child lives:**

**Father's Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ M.I. \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**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: \_\_\_\_\_

SSN: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation \_\_\_\_\_ Title: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

**Mother's Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ M.I. \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**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: \_\_\_\_\_

SSN: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation \_\_\_\_\_ Title: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

**Step-Father's Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ M.I. \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

**Step-Mother's Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ M.I. \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

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**The person requesting services for a minor 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 today by cash, check or credit card. (We accept MasterCard or Visa.)

**Photo Release:**

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

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

I hereby assign all medical benefits (to which my child is entitled) to the doctor caring for my child. 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 needed to process my insurance claims. I understand that I am the guarantor of this account.

A copy of my child's 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:** \_\_\_\_\_

INFANT/TODDLER/PRESCHOOLER VISION HISTORY

When completing this for a minor child, please be sure to answer the questions with regard to him/her. Be careful to fill in every blank. This will help Dr. Vicky Vandervort to better understand your child's condition. Please mail or fax this form to us or bring it with you to your appointment. Thank you!

First Appointment: Day Date Time

CHILD'S FULL NAME Male Female
DOB AGE: years months
Delivery Due Date:

PARENT'S FULL NAMES:

Mother Father
Step-Mother Step-father

VISUAL HISTORY

Why do you believe your child needs a visual examination?

Has your child's vision been previously evaluated? Yes No

If so, Doctor's Name: Date of last evaluation:

Reason for examination:

Results and recommendations:

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

If yes, what?

Are they used? Yes No If yes, when?

If not used, why not?

Was surgery, therapy or other treatment recommend? Yes No

If yes, what?

Members of the family who have had visual problems and the reason:

Table with 3 columns: Name / Relationship, Age, Visual Problem

Please check "yes" or "no" to the following observations and/or complaints as they relate to your child:

Table with 4 columns: Observation, Yes, No, If yes, when?

DATE OF COMPLETION \_\_\_\_\_

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
Has watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Turns head to use one eye only	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tilts head to one side	<input type="checkbox"/>	<input type="checkbox"/>	_____
Moves objects very close to look at them	<input type="checkbox"/>	<input type="checkbox"/>	_____
Squints while looking at objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blinks excessively	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has a tendency to rub eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Covers or closes one eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stumbles over objects or is clumsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor motor control	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lacks interest in looking at objects or seeing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unable to see distant objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unable to transfer object from hand to hand, or crossing the midline of the body	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is unable to stack blocks or other objects	<input type="checkbox"/>	<input type="checkbox"/>	_____

Does your child verbalize any problems/complaints about his/her eyes or vision? Yes  No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY**

Pediatrician's Name: \_\_\_\_\_ Date of Last Evaluation: \_\_\_\_\_

For what reason? \_\_\_\_\_

Results and recommendations: \_\_\_\_\_  
\_\_\_\_\_

Medications currently using, including vitamins and supplements: \_\_\_\_\_  
\_\_\_\_\_

For what condition(s)? \_\_\_\_\_  
\_\_\_\_\_

Are child's immunizations up to date?  Yes  No If no, explain: \_\_\_\_\_

Any reactions to immunization(s)?  Yes  No If yes, explain: \_\_\_\_\_

Is your child generally healthy?  Yes  No

If no, explain: \_\_\_\_\_

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

<u>Age</u>	<u>Severe</u>	<u>Mild</u>	<u>Complications</u>
_____	_____	_____	_____
_____	_____	_____	_____

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

If yes, please list: \_\_\_\_\_

Has a neurological evaluation been performed?  Yes  No

By whom? \_\_\_\_\_ Results and recommendations: \_\_\_\_\_  
\_\_\_\_\_

Has a psychological evaluation been performed? Yes  No

By whom? \_\_\_\_\_ Results and recommendations: \_\_\_\_\_  
\_\_\_\_\_

Has an occupational therapy evaluation been performed? Yes  No

By whom? Results and recommendations: \_\_\_\_\_  
\_\_\_\_\_

Is there any history of the following? (please check if there is a history):

	<u>Patient</u>	<u>Family</u>	<u>Who</u>		<u>Patient</u>	<u>Family</u>	<u>Who</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Turn (not straight)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chromosomal imbalance	<input type="checkbox"/>	<input type="checkbox"/>	_____	Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____

If other, please explain: \_\_\_\_\_  
\_\_\_\_\_

**DEVELOPMENTAL HISTORY**

Full-term pregnancy?  Yes  No

Did the mother experience any health problems during the pregnancy?  Yes  No

If yes, explain: \_\_\_\_\_

Normal birth?  Yes  No

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

If yes, explain: \_\_\_\_\_

Birth weight: \_\_\_\_\_ APGAR scores @ birth: \_\_\_\_\_ After 10 minutes: \_\_\_\_\_

Were there any difficulties at all in feeding (such as difficulty with sucking, vomiting?)  Yes  No

If yes, explain: \_\_\_\_\_

Any problems with colic?  Yes  No

Was there ever any reason for concern over your child's general growth or development?  Yes  No

If yes, why? \_\_\_\_\_

Has your child received any special developmental guidance/ assistance/therapy?  Yes  No

If yes, explain: \_\_\_\_\_

How many hours daily does your child sleep? \_\_\_\_\_

Does your child sleep through the night?  Yes  No If yes, starting at what age: \_\_\_\_\_

If no, explain: \_\_\_\_\_

What percent of the *waking* hours is/was your child in a playpen/crib/carseat? \_\_\_\_\_

In a walker? \_\_\_\_\_

In a seat? \_\_\_\_\_

What things can your child do very well? \_\_\_\_\_  
\_\_\_\_\_

What things, if any, are difficult for your child? \_\_\_\_\_  
\_\_\_\_\_

**NUTRITIONAL INFORMATION**

Current Diet:  Breast Fed  Breast Fed until what age: \_\_\_\_\_  Bottle fed

Solid food started at what age: \_\_\_\_\_ What type? \_\_\_\_\_

Are there any food allergies/sensitivities?  Yes  No

If yes, what: \_\_\_\_\_

Activity Level:  High  Moderate  Low

Are there periods of very high energy  Yes  No

Are there periods of very low energy?  Yes  No

Does your child:  Like sweets or  Crave sweets

If so, what? \_\_\_\_\_

What are his/her favorite foods? \_\_\_\_\_

What are his/her disliked/avoided foods? \_\_\_\_\_

### **PRE-SCHOOL**

\*\*\*If your child attends pre-school, please fill out the following\*\*\*:

Name of Pre-school: \_\_\_\_\_ Teacher: \_\_\_\_\_ Director: \_\_\_\_\_

Age at time of entrance to pre-school: \_\_\_\_\_

Does your child like pre-school?  Yes  No

Does your child like the teacher?  Yes  No

Compared to other children his/her age, do his/her general performance and social skills seem to be  
 above  equal to  below

Please explain: \_\_\_\_\_

Which pre-school activities are easy for your child? \_\_\_\_\_

Which pre-school activities are difficult for your child? \_\_\_\_\_

Specifically describe any pre-school / day care concerns / difficulties: \_\_\_\_\_

Does your child seem to be under tension at pre-school/day care?  Yes  No

If yes, explain: \_\_\_\_\_

### **CURRENT ABILITIES/BEHAVIOR**

List the age at which your child could do the following: (Mark N/A if your child has not yet accomplished these behaviors/abilities).

	Age		Age
Responsive smile	_____	Stack blocks	_____
Crawl (stomach on floor)	_____	Walk alone	_____
Roll over	_____	Scribble spontaneously	_____
Creep (stomach of floor)	_____	Kick a ball	_____
Sit up alone	_____	Walk up steps with help	_____
Respond to words and names	_____	Use two-word sentences	_____
Say single words	_____	Toilet-trained	_____
Give first name	_____	Put on some clothing alone	_____

Can your child identify colors? Yes  No  If yes, which? \_\_\_\_\_

Can your child identify numbers or letters? Yes  No  If yes, which? \_\_\_\_\_

Does your child like to draw/color? Yes  No

Is your child learning to read? Yes  No

How is your child performing compared to others his/her age:

Above average  Average  Below average

How well developed is your child's spoken vocabulary? \_\_\_\_\_

How well does your child understand/respond to spoken language? \_\_\_\_\_

**Check the appropriate spaces if you have any concerns about the following behavior(s) in your child:**

- |                    |                          |  |                          |
|--------------------|--------------------------|--|--------------------------|
| Lack of curiosity  | <input type="checkbox"/> | Irritable, easily upset                | <input type="checkbox"/> |
| Thumb-sucking      | <input type="checkbox"/> | Restlessness                           | <input type="checkbox"/> |
| Nervous            | <input type="checkbox"/> | Has difficulty separating from parents | <input type="checkbox"/> |
| Glum, sulky, moody | <input type="checkbox"/> | Sleeplessness                          | <input type="checkbox"/> |
| Bad temper         | <input type="checkbox"/> | Lethargic, low energy                  | <input type="checkbox"/> |
| Passive            | <input type="checkbox"/> | Aggressive                             | <input type="checkbox"/> |

Other (please explain): \_\_\_\_\_  
\_\_\_\_\_

**GIVE A BRIEF DESCRIPTION OF YOUR CHILD AS A PERSON:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there any other information that would be helpful or important in our evaluation or treatment of your child?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Who completed this form?**

- Mother Father Step-Mother Step-Father Adoptive Parents Foster Parents Grandmother  
Grandfather Aunt Uncle Other Caretaker (please specify) \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

**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