

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)

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: ___/___/___

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:** _____

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

PEDIATRIC PATIENT HISTORY

Date of Completion: _____

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 better understand your child's condition. Thank you.

NAME _____ DOB ____/____/____ AGE _____ GRADE _____

PARENT'S FULL NAMES: Mother _____ Father _____

Step-Mother _____ Step-father _____

What is the **MAIN REASON** you are seeking care for your child today? (Be as specific as you can be.)

Age of first eye exam? _____ years Were glasses prescribed? Yes/No Were glasses actually worn? Yes/No

Date of your child's most recent eye examination? _____ performed by Dr. _____

Date of your child's most recent physical exam? _____ performed by Dr. _____

IS SCHOOL PERFORMANCE: (circle) Below Average Average Above Average Not applicable

MOST DIFFICULT SUBJECT: (circle one) Reading Math Spelling

Has your child complained to you (prior to today) about the following symptoms?
Please mark "N" for never, "S" for sometimes, and "O" for often. Please mark something in every blank.

Flashes of light _____ Floaters/spots _____ Blackouts _____
Itching _____ Burning _____ Redness _____
Eye strain _____ Eye pain _____ Blur at near _____
Light sensitivity _____ Tearing _____ Blur at distance only after reading _____
Double vision (1 object seen as 2) _____ Blur at distance all of the time _____

Does your child have any problems with (circle Yes or No for every question)

Blood? Yes No Heart? Yes No Breathing? Yes No Skin? Yes No
Hormones? Yes No Bladder? Yes No Stomach/Intestines? Yes No
Allergies Yes No Ears, Nose, Mouth, Throat? Yes No

If yes, please describe _____

Is your child presently taking any prescription medications? (circle) Yes No

Please list all medications and amount taken _____

Are there any immediate family members (parent, sibling, grandparents, aunts/uncles) with any of the following?
Please put a "Y" or an "N" in every blank.

Glaucoma? _____ If yes, who? _____
Cataracts? _____ If yes, who? _____
Diabetes? _____ If yes, who? _____
High Blood Pressure? _____ If yes, who? _____
Thyroid Disease? _____ If yes, who? _____
Heart Disease? _____ If yes, who? _____

Please continue on next page

Has your child ever had a concussion? (circle) Yes No If yes, when? _____
Has your child been in an automobile accident? (circle) Yes No If yes, when? _____
Has a neurologist examined your child? (circle) Yes No Dr. _____
Has your child ever had an injury to his/her face or eyes? (circle) Yes No If yes, when? _____

Has your child complained to you about headaches? (circle) Yes No

If No, skip the following section.

How frequent are the headache complaints? (circle)
Daily 1-2 per Week 3-4 per Week Monthly Infrequently
What is the location of HA pain? (circle) Temples Forehead Top of Head Back of Head Neck
What is the nature of the pain? (circle all that apply) Dull Sharp Constant Throbbing
How long does the HA usually last? _____
How long has your child suffered from these HA's? _____
What time of day do your child's HA's usually occur? (circle) Mornings Afternoons Evenings

Does either of your child's eyes turn inward (cross) or float outward? (circle) Yes No

If No, skip this section.

Which eye turns/floats? (circle) Right Left Sometimes left, Sometimes Right
Which way does it turn/float? (circle) In Out Up Down
Is the eye *always* turned/floating? (circle) Yes No If not, *when* does it usually turn? _____

How much of the time is the eye turned/floating? _____ % of waking hours
Is the eye turn/floating apparent to others? (circle) Yes No
Is it getting (circle) Better? Worse? About the Same?
Was there any related trauma, fever, disease or condition that accompanied the onset of the eye turn/float?
(circle) Yes No If yes, please explain:

Are there any other family members with an eye turn/float? (circle) Yes/No If yes, please list relationship to your child _____

Are there any family members with lazy eye (reduced vision in one eye even with best prescription) (circle) Yes/No

If yes, please list relationship to your child: _____

Has your child ever undergone patching therapy? (circle) Yes/No If yes, at what age? _____

Which eye was patched? R/L How many hours per day? _____ How many months? _____

Do you have broadband internet? Yes No

How much time does your child spend on the internet/computer? _____

Do you have cable TV in your home? Yes No How much TV does your child watch per day? _____

Do you wish to add anything not covered? _____

Please give to the receptionist immediately upon checking in. Thank you!