Revised 4/13/2016

Pediatric Medical History

Date of last eye exam _____

Child's Full Name _____ Today's Date ____/____/____
Last, First, Middle Mo. Day Yr.

Nickname or Preferred Name _____ Birthdate _____/_____/_____
Mo. Day Yr.

Child's Address _____
Street, City, State, Zip

Ethnicity/Race (Circle) White/Asian/Native Hawaiian/Pacific Islander/Black or African American/American Indian or Alaskan Native/Hispanic/Latino

Name(s) of Parent (s) _____ Occupation _____
_____ Occupation _____

Child lives with: Both Parents Natural Parent(s) Other _____
Father Adoptive Parent(s)
Mother

Phone Number: Home ( ) Work ( )

Name of Child's School _____ Grade _____

Name of Primary Care Doctor _____

What is the reason for this examination? _____
_____

Medical Information

1. Please indicate child or family (parents, grandparents, siblings) history of the following (Check all that apply):

Child	Family		Child	Family	
☐	☐	Birth defects	☐	☐	Bleeding Disorders
☐	☐	Diabetes	☐	☐	Mental or emotional disorders
☐	☐	Seizures	☐	☐	Learning disabilities
☐	☐	Cancer	☐	☐	Asthma
☐	☐	Heart Disease	☐	☐	High Blood Pressure
☐	☐	Strokes	☐	☐	Eye Disorders (explain)

_____
_____

2. Has your child ever been hospitalized? ☐Yes ☐No If Yes, please explain

_____

3. Is your child currently under a doctor's care? ☐Yes ☐No If Yes, please explain

_____

4. Does your child take any medication(s) at this time? ☐Yes ☐No If Yes, please explain

_____

5. Were there any problems during the birth of your child

During pregnancy? ☐Yes ☐No At delivery? ☐Yes ☐No

During labor? ☐Yes ☐No Immediately following birth? ☐Yes ☐No

If Yes, please explain: _____

6. Your child was delivered: ☐On time ☐Early How early? _____ ☐Late

Delivery was: ☐Normal ☐C-section

Birth weight _____lbs._____oz. Apgar scores (if known)_____ _____

7. Does your child have a history of allergies? ☐Yes ☐No

If Yes, explain: _____

A history of ear infections? ☐Yes ☐No

If Yes, explain: _____

Any complications with chicken pox, mumps, measles? ☐Yes ☐No

If Yes, explain: _____

Any other illnesses with very high fever (temperature 104◦ or more? ☐Yes ☐No

Has your child had any surgeries? ☐Yes ☐No

If Yes, explain: _____

8. Is your child in any therapy? Speech Occupational Therapy Physical Therapy
(Please Circle) Resource Tutoring

School Information:

1. Date entered kindergarten: _____ (mo.) _____ (yr.) Age _____
Date entered first grade: _____(mo.) _____ (yr.) Age _____

2. Does your child enjoy school? ☐Yes ☐No

Does your child like his/her teacher? ☐Yes ☐No

Is school attendance regular? ☐Yes ☐No If No, why?_____

3. Has your child ever repeated any grade? ☐Yes ☐No

4. In your opinion, what is your child's favorite school subject? _____
   Easiest subject? _____ Hardest subject? _____

5. Has your child had any remedial work? ☐Yes ☐No
   If Yes, when? _____ In what subject? _____ From whom? _____

6. Has your child changed schools or teachers? ☐Yes ☐No
   If Yes, how often? _____ When and why? _____

7. Has your child ever had: Educational testing ☐Yes ☐No
   Psychological or audiological testing ☐Yes ☐No
   Medical testing (non-routine) ☐Yes ☐No
   If Yes, when? _____ Explain: _____

8. Is your child receiving any special educational services? ☐Yes ☐No
   If Yes, what is the service? _____

Guarantor Information: (Person Responsible for the account)

Name (Last)_____(First)_____(Middle)_____Soc. Sec#_____
Birth Date:_____Street Address:_____City:_____State:_____Zip:_____
Patient Relationship to Guarantor:___Self___Child___Parent___Spouse___Other

Primary Insurance:_____***Holder Name:***_____***DOB:***_____***SS:***_____
Plan name:_____ID#:_____Group:_____
Patient Relationship to Holder: ____Self____Child____Other

Secondary Insurance:_____***Holder Name:***_____***DOB:***_____***SS:***_____
Plan name:_____ID#:_____Group:_____
Patient Relationship to Holder: ____Self____Child____Other

Other Family Members who are current Patients:

Name:_____ Name:_____

In case of an emergency, list who we may contact:

Contact Name:_____Phone#:_____Relation:_____
Contact Name:_____Phone#:_____Relation:_____

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NOTICE FOR FILING OF INSURANCES

I understand that I am **financially responsible** for all services incurred today. This financial responsibility includes any deductible, co-insurance, non-covered services.

I agree that the insurance information given to you today is current and should I have out of network Primary and or Secondary insurance, that I am responsible for the cost of today's visit. I understand that payment is due at the time services are rendered, and that I am to furnish any and all explanation of benefits upon receipt of same to the doctor's office for filing of my secondary insurance, should it apply.

I HEREBY authorize release of medical information necessary to file a claim with my insurance with benefits made on my behalf to Dr. Wanda Vaughn for services rendered.

_____ _____

Patient or Responsible Party Signature Date

RELEASE OF INFORMATION TO SCHOOL

I give Arkansas Vision Development Center permission to release information regarding_____ ocular health and binocular status to the school listed in the above form.

_____ _____

Parent/Guardian
Signature Date

****Due to HIPPA , no information will be faxed to the school. If the school needs information, we will be happy to mail it to them, With a signed request/release of information, by an authorized representative.***

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Consent to Treatment:

I voluntarily consent to outpatient care which may encompass examination and medical or visual treatment, and administration of medications as ordered by the physician.

I understand the performance of examinations, diagnostic procedures, and rendering of treatment will be by the Physician. Other services my be rendered by their clinical assistants by direct order of the Physician.

I authorize the release of medical/treatment information to the insurance carrier I have identified in enrollment data for the purpose of filing claims related to my medical or vision care. I hereby authorize the attending medical provider to release all information necessary to secure the payment of benefits. I authorize the use of my signature below on all insurance submissions.

I authorize the release of pertinent medical and treatment documentation to other physicians involved in by care through referral or shared care.

I agree to assignment and release of insurance benefits to Arkansas Vision Development Center, for all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges incurred whether or not paid by insurance.

I understand that a photograph is included as a part of my electronic health record. I relieve Arkansas Vision Development Center, of any use of my Photograph for treatment, identification, or education purposes acknowledging that uses for any other purposes must be specifically obtained from me.

_____ _____

Patient or Responsible Party Signature Date

As the Parent or legal guardian for a minor child, I am consenting for my child to receive treatment.

_____ _____

Name of Minor Patient Responsible Party Signature

19 Item COVD-QOL Checklist Questionnaire

Name: _____ DATE: _____ GRADE LEVEL: _____

Check the column which best represents the occurrence of each symptom

	NEVER	SELDOM	OCCASIONAL	FREQUENTLY	ALWAYS
Headaches with near work					
Words run together reading					
Burn, itch, watery eyes					
Skips/repeats lines reading					
Head tilt/close one eye when reading					
Difficulty copying from chalkboard					
Avoids near work/reading					
Omits small words when reading					
Writes up/down hill					
Misaligns digits/columns of numbers					
Reading comprehension down					
Holds reading too close					
Trouble keeping attention on reading					
Difficulty completing assignments on time					
Always says "I can't" before trying					
Clumsy, knocks things over					
Does not use his/her time well					
Loses belongings/things					
Forgetful/poor memory					

OTHER COMMENTS

Arkansas Vision Development Center
Dr. Wanda Vaughn, O.D., F.C.O.V.D.
479.478.8860

Other therapies:

☐ Speech ☐ Occupational Therapy ☐ Physical Therapy ☐ Resource ☐ Tutoring

Arkansas

Vision

Development Center

CONSENT TO TREATMENT OF A MINOR WHEN PARENTS/GUARDIANS ARE TEMPORARILY UNAVAILABLE

The undersigned parent or legal guardian of_____authorizes the person(s) listed below to consent to treatment of the child, including, but not limited to, eye exams, office visits, treatment, and/or visual rehabilitation therapy, when I am not immediately available in person, or by a telephone call to _____.

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

   Name:_____Relationship to Child:_____Phone:_____

   Name:_____Relationship to Child:_____Phone:_____

   Name:_____Relationship to Child:_____Phone:_____

2. Known Medical concerns:_____
3. Known Allergies:_____

Name of Parent or Legal Guardian:_____Relationship to Child:_____

Contact number(s):_____

Address:_____City,State, Zip_____

Signature:_____Date:_____

This Consent is effective until withdrawn in writing by the child's parent or guardian.