

## PATIENT INFORMATION

IT IS NECESSARY THAT ALL REQUESTED INFORMATION IS FILLED OUT

Child's Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address: Number \_\_\_\_\_ Street \_\_\_\_\_ Apt# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

(\_\_\_\_) (\_\_\_\_) Home Telephone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Male  
 Female

Parent/Guardian Name FIRST \_\_\_\_\_ LAST \_\_\_\_\_

Parent/Guardian Name FIRST \_\_\_\_\_ LAST \_\_\_\_\_

### IN THE PAST YEAR, HAS YOUR CHILD RECEIVED:

• AN EYE EXAM FROM AN EYE DOCTOR? **Yes / No**

• EYEGLASSES FROM AN EYE DOCTOR? **Yes / No**

IF SO, WHEN? \_\_\_\_\_ (date of last eye exam)

Eye Doctor Name \_\_\_\_\_

Address of Eye Doctor \_\_\_\_\_

### THE EYE EXAM:

As part of a comprehensive eye examination, eye drops are used that will temporarily relax the eye, making the pupils large and preventing the ability to focus on near objects. There may be some mild stinging for a few seconds when the drops are administered. The pupils will remain large for approximately six hours. These drops are routinely used in eye exams of babies and children, and are standard eye-care procedures in a doctors' office for an eye exam. →

## INSURANCE INFORMATION

### Mass Health Card Number

Policy Number \_\_\_\_\_

### Other Health Insurance

Insurance Plan Name: \_\_\_\_\_

Policy # \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

My child does not have health insurance at this time. I would like to know other options for my child to receive eye-care through this program.

I hereby authorize New England Eye Institute doctors to examine my child. I understand that giving my authorization will allow a complete eye exam to be conducted, including dilation of his/her eyes by putting drops in them. I authorize New England Eye to share results of my child's exam with his/her teachers, school nurses and other appropriate school personnel.

I also hereby authorize New England Eye Institute to release any information necessary for billing purposes and disclose my medical information for treatment, payment or health care operations. I assign all medical benefits to which I am entitled to New England Eye Institute. I agree that I am responsible for any co-payments or deductibles as stated in any Explanation of Benefits. To the best of my knowledge all of the above information is true and accurate.

I have read and understand the eye program and I consent to have my child participate. A "Notice of Privacy Practices" was made available to me.

**X** \_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

PRINT NAME \_\_\_\_\_ / DATE \_\_\_\_\_

RELATIONSHIP TO CHILD \_\_\_\_\_ / (\_\_\_\_) \_\_\_\_\_  
CELL PHONE NUMBER

# NEW ENGLAND EYE ON-SIGHT

Mobile Eye Clinic



*is coming to your school!*

Your child can receive:

- a comprehensive eye exam given by a pediatric eye doctor
- a prescription for eyeglasses, if needed
- eyeglasses, ordered on the day of your child's eye exam
- eye exam results, in a letter sent home or a phone-call, with recommendations for follow-up eye-care

**IT IS RECOMMENDED SCHOOL CHILDREN RECEIVE A COMPREHENSIVE EYE EXAM EVERY 1 – 2 YEARS.**

- YES, I WOULD LIKE MY CHILD TO HAVE A COMPREHENSIVE EYE EXAM
- NO, I DO NOT GIVE PERMISSION FOR MY CHILD TO PARTICIPATE IN THIS PROGRAM

NAME OF CHILD: \_\_\_\_\_

SCHOOL: \_\_\_\_\_

CONTACT: [www.newenglandeye.org](http://www.newenglandeye.org)  
(617)-587-5700

OVER →

NAME OF CHILD: \_\_\_\_\_

# Your Child's Eye Health

Name of Child's

Address of Child's Pediatrician/Doctor:

Pediatrician: \_\_\_\_\_

Pediatrician Phone No: \_\_\_\_\_

### Recent Eye Symptoms:

Yes No	How long?	Yes No	How long?
<input type="checkbox"/>	Blurred vision _____	<input type="checkbox"/>	Crossed or wandering eye _____
<input type="checkbox"/>	Tired eyes when reading _____	<input type="checkbox"/>	Frequent tearing or discharge _____
<input type="checkbox"/>	Excessive squinting _____	<input type="checkbox"/>	Light Sensitivity _____
<input type="checkbox"/>	Frequent Headaches _____	<input type="checkbox"/>	Clumsiness or bumping into things _____
<input type="checkbox"/>	Double vision _____	<input type="checkbox"/>	Change in performance in school _____
<input type="checkbox"/>	Excessive eye rubbing _____	<input type="checkbox"/>	Difficulty learning _____

### History of Eye Problems: Has the patient had any of the following?

Yes No	Age	Yes No	Age	Describe
<input type="checkbox"/>	An eye exam from Eye-doctor _____	<input type="checkbox"/>	Eye injury _____	_____
<input type="checkbox"/>	Glasses _____	<input type="checkbox"/>	Eye surgery _____	_____
<input type="checkbox"/>	Patching _____	<input type="checkbox"/>	Other eye problems _____	_____

### Birth History:

Birth Weight: \_\_\_lb. \_\_\_oz.

Yes No	If yes, what was problem?	Yes No	If yes, why?
<input type="checkbox"/>	Problems during pregnancy _____	<input type="checkbox"/>	Delivered more than 2 weeks early or late _____
<input type="checkbox"/>	Problems during delivery or forceps delivery _____	<input type="checkbox"/>	Baby kept in hospital due to illness _____
<input type="checkbox"/>	Cesarean section _____	<input type="checkbox"/>	Delayed development _____

### Other Medical Problems:

Yes No	Yes No
<input type="checkbox"/>	Asthma _____
<input type="checkbox"/>	Frequent ear infections _____
<input type="checkbox"/>	Other ear, nose or throat problems _____
<input type="checkbox"/>	Heart problems _____
<input type="checkbox"/>	Lung disease _____
<input type="checkbox"/>	Neurological problems _____
<input type="checkbox"/>	Fever or weight loss _____
	Allergies (please list): _____
	_____
	_____

### Medications:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

### Family History: Have any of the patient's relatives (mother, father, sister, brother) had any of the following?

Yes No	Who?	Yes No
<input type="checkbox"/>	Blindness _____	<input type="checkbox"/>
<input type="checkbox"/>	Amblyopia (lazy eye) _____	<input type="checkbox"/>
<input type="checkbox"/>	Patching treatment _____	<input type="checkbox"/>
<input type="checkbox"/>	Strabismus (crossed eye) _____	<input type="checkbox"/>
<input type="checkbox"/>	Eye muscle surgery _____	<input type="checkbox"/>
<input type="checkbox"/>	Glasses before age 6 _____	<input type="checkbox"/>
<input type="checkbox"/>	Cataracts in childhood _____	<input type="checkbox"/>
<input type="checkbox"/>	Glaucoma in childhood _____	<input type="checkbox"/>
	Are both parents alive and in good health? _____	

### Child's Ethnicity/Race?

- |   |  |
|---|--|
| <input type="checkbox"/> White/Caucasian                    | <input type="checkbox"/> Asian                       |
| <input type="checkbox"/> Black or African American          | <input type="checkbox"/> Native Hawaiian/Pacific Is. |
| <input type="checkbox"/> Hispanic, Latino or Spanish origin | <input type="checkbox"/> Other race _____            |
| <input type="checkbox"/> American Indian or Alaska native   | _____  |

Reviewed by:

Dr. \_\_\_\_\_  
Date \_\_\_\_\_