

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 the 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.

ALL CHILDREN ARE REQUIRED TO HAVE A VISION SCREENING OR A COMPREHENSIVE EYE EXAM BEFORE ENTERING KINDERGARTEN.



- 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: (617)-587-5700
www.newenglandeye.org

OVER →

NAME OF CHILD: _____

Your Child's Eye Health

Name of Child's
Pediatrician: _____

Address of Child's Pediatrician/Doctor:

Pediatrician Phone No: _____

Recent Eye Symptoms:

Yes	No	How long?	Yes	No	How long?
<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision _____	<input type="checkbox"/>	<input type="checkbox"/>	Crossed or wandering eye _____
<input type="checkbox"/>	<input type="checkbox"/>	Tired eyes when reading _____	<input type="checkbox"/>	<input type="checkbox"/>	Frequent tearing or discharge _____
<input type="checkbox"/>	<input type="checkbox"/>	Excessive squinting _____	<input type="checkbox"/>	<input type="checkbox"/>	Light Sensitivity _____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches _____	<input type="checkbox"/>	<input type="checkbox"/>	Clumsiness or bumping into things _____
<input type="checkbox"/>	<input type="checkbox"/>	Double vision _____	<input type="checkbox"/>	<input type="checkbox"/>	Change in performance in school _____
<input type="checkbox"/>	<input type="checkbox"/>	Excessive eye rubbing _____	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	An eye exam from Eye-doctor _____	<input type="checkbox"/>	<input type="checkbox"/>	Eye injury _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Glasses _____	<input type="checkbox"/>	<input type="checkbox"/>	Eye surgery _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Patching _____	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	Problems during pregnancy _____	<input type="checkbox"/>	<input type="checkbox"/>	Delivered more than 2 weeks early or late _____
<input type="checkbox"/>	<input type="checkbox"/>	Problems during delivery or forceps delivery _____	<input type="checkbox"/>	<input type="checkbox"/>	Baby kept in hospital due to illness _____
<input type="checkbox"/>	<input type="checkbox"/>	Cesarean section _____	<input type="checkbox"/>	<input type="checkbox"/>	Delayed development _____

Other Medical Problems:

Yes	No	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma _____	<input type="checkbox"/>	Attention Deficit Disorder _____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent ear infections _____	<input type="checkbox"/>	Does child have an Individual Education Plan (IEP)? _____
<input type="checkbox"/>	<input type="checkbox"/>	Other ear, nose or throat problems _____	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart problems _____	<input type="checkbox"/>	Allergies (please list): _____
<input type="checkbox"/>	<input type="checkbox"/>	Lung disease _____		_____
<input type="checkbox"/>	<input type="checkbox"/>	Neurological problems _____		_____
<input type="checkbox"/>	<input type="checkbox"/>	Fever or weight loss _____		_____

Medications:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 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"/>	<input type="checkbox"/>	Blindness _____	<input type="checkbox"/>	<input type="checkbox"/>	Other serious eye disease: _____
<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia (lazy eye) _____	<input type="checkbox"/>	<input type="checkbox"/>	Other serious illnesses: _____
<input type="checkbox"/>	<input type="checkbox"/>	Patching treatment _____			
<input type="checkbox"/>	<input type="checkbox"/>	Strabismus (crossed eye) _____	<input type="checkbox"/>	<input type="checkbox"/>	Are both parents alive and in good health? _____
<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 _____			

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 _____