

The VISION Development Team

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Insurance Information

Medical Insurance Co. _____
Subscriber Name _____
Relationship to Patient _____
ID# _____ Group# _____
Subscriber Birth Date _____
Subscriber Employer _____

Welcome to Our Office

Date _____
Patient Name _____
Street _____
City _____ State _____ Zip _____
Mobile# _____
Home# _____ Work# _____
E-mail _____
Employer (or School) _____
Occupation (or Grade) _____
Date of Birth _____ Age _____ Sex: M F
Marital Status: S M D W

What are your major concerns (and or) needs that you would like addressed today?

Any problems with your present contact lenses or glasses?

How will you settle your account today?

- Cash
- Check
- Credit Card (MasterCard/Visa/Discover/Amex)
- CareCredit

Financial Policy

Release of Information

Privacy Practices Acknowledgement

The Vision Development Team extends the courtesy of filling out a medical insurance claim form for you to submit to your insurance company for reimbursement to you.

I understand that I will be required to pay for services at the time rendered.

I authorize Alexandar Andrich, OD, FCOVD to release any information required by my insurance company.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature: _____ Date: _____
(Guardian signature required if patient is under 18)

VERY IMPORTANT! NEW PATIENTS ONLY

Who may we thank for referring you to our office?

Name

How did you choose our office for your needs?

- Internet search
- Optometrist
- Ophthalmologist
- Pediatrician – Family Physician
- Neurologist
- Cleveland Clinic Metro Cleveland Sight Center
- OT – PT – Speech – Other therapy
- School
- Other _____

*Please silence cell phones prior to entering the Doctor's exam room.
Thank you!*



The **VISION** Development Team

info@sensoryfocus.com
www.sensoryfocus.com

For what condition? _____
Drug allergies _____

School Age Child History

Please bring this form to your child's appointment or return by email before the appointment. If your child has had an Individualized Education Program (IEP), or other testing which the doctor should be aware of, please provide a copy.

General Information

Child's full name _____
Age _____ Birth date _____
School _____
School Address _____

Grade _____ Teacher _____
Principal _____
Is your child especially afraid of doctors? Yes No

Parent(s) Information

Full Name _____
Relationship _____
Home Address Same as patient address on Welcome Form
Address _____
City _____ State _____ Zip _____
Phone: H _____ C _____
E-mail _____
Occupation _____
Employer _____
Work Phone _____

Full Name _____
Relationship _____
Home Address Same as patient address on Welcome Form
Address _____
City _____ State _____ Zip _____
Phone: H _____ C _____
E-mail _____
Occupation _____
Employer _____
Work Phone _____

Medical History

Most recent medical examination:
Doctor's name _____
Date _____
Results _____

Medications currently using? _____

Has your child been diagnosed as having:

- Learning disabilities
- ADD or ADHD
- Seizure disorders
- Brain injury
- Auditory Processing Delay
- Other _____
- Developmental delays
- Cerebral Palsy
- Autism
- Dyslexia

List illnesses, bad falls, head injuries, ear infections, high fever etc. (include complications and ages)

Is your child generally healthy? _____
Are there any chronic problems like asthma, hay fever, allergies? _____
If so, please list _____

Has a neurological evaluation been performed? Yes No
By whom? _____
Results _____

Has a psychological evaluation been performed? Yes No
By whom? _____
Results _____

Does your child currently receive:
Occupational therapy services? Yes No
By whom? _____
Results _____

Physical therapy services? Yes No
By whom? _____
Results _____

Speech therapy services? Yes No
By whom? _____
Results _____

Auditory Training? Yes No
Other therapy services? Yes No

Describe _____

Nutritional Information

Current Diet: Excellent Good Fair Poor
Does your child crave sweets? _____
Is your child Moderately active Extremely active
Are there periods of high energy? Yes No
Low energy? Yes No

Developmental History

Full term pregnancy? Yes No Normal Birth? Yes No
Birth weight? _____
Any complications before, during, after or immediately following delivery? _____
Did your child crawl (stomach **on** floor)? Yes No
Age _____
Did your child creep (stomach **off** floor)? Yes No
Age _____
Did your child move on all fours? Yes No
Age _____
If not describe _____

At what age did your child walk? _____
Was child active? Yes No
Speech: First words at age _____
Was early speech clear to others? Yes No
Is it clear now? Yes No
Any history of crossing eyes? Yes No
What age first noticed _____
Any **family** history of crossing eyes? Yes No
Who? _____

Visual History

Previous eye examination: Doctor's name _____
Date _____
Reason for examination _____
Results _____
Were glasses prescribed? Yes No
Are they worn? Yes No Full-time Part-time
Comments _____
Are eye exams done yearly? Yes No
Members of the family who have had visual attention and why:
Name **Age** **Visual Situation**

Present Situation

Is there any concern from any other professional that some visual dysfunction may be present? Yes No
Describe _____

Does your child report any of the following:
Headaches Yes No
When? _____
Blurred vision Yes No
When? _____
Double vision Yes No
When? _____
Eyes "hurt or tired" Yes No
When? _____
List any other complaints that your child makes concerning his/her vision _____

Have you ever noticed the following:

Eyes frequently reddened Yes No
If so, when? _____
Frequent eye rubbing Yes No
If so, when? _____
Frequent blinking Yes No
If so, when? _____
Closing or covering one eye Yes No
If so, when? _____
Head close to paper when reading or writing Yes No N/A
Tilting head when reading Yes No N/A
Tilting head when writing Yes No N/A
Confuses letters or words Yes No N/A
Reverses letters or words Yes No N/A
Skips, rereads or omits words Yes No N/A
Vocalizes when reading silently Yes No N/A
Reads slowly Yes No N/A
Uses finger as a marker Yes No N/A

- Poor reading comprehension Yes No N/A
- Writes or prints poorly Yes No N/A
- Tires easily Yes No N/A
- Avoids near tasks Yes No N/A
- Short attention span Yes No N/A
- Poor motor coordination Yes No N/A
- Difficulty catching/hitting a ball Yes No N/A
- Television viewing: How much _____
- How often _____ Viewing distance _____
- Average amount of sleep per night _____

School

- Age at entrance to kindergarten _____
- Does child like school? Yes No
- Teacher? Yes No
- School work is: Above Average
 Average
 Below Average

Do you feel he/she is working up to potential? _____

Does teacher feel he/she is working up to potential? _____

What school subjects come easy for child? _____

Does child like to read? Yes No

Voluntarily? Yes No

What? _____

Specifically describe any school difficulties: _____

Has a grade been repeated? Yes No

Which? _____

Has he/she changed schools often? _____

When? _____

Does he/she seem to be under tension or extreme pressure when doing schoolwork? _____

Has he/she had any special tutoring and/or remedial assistance? Yes No

When? _____

From whom? _____

Where? _____

How long? _____

Results _____

How well developed is his/her spoken vocabulary? _____

What is the child's attitude toward reading, school, his/her teacher, other youngsters? _____

General Behavior

Are there any behavior problems? Yes No

School _____ Home _____

What causes these problems? _____

Child's reaction to fatigue: None Sad Irritable

Other _____

Child's reaction to tension? None Nail biting

Thumb sucking Other _____

Does he/she say and/or do things impulsively? Yes No

Is your child in constant motion? Yes No

Can your child sit still for long periods? Yes No

Family and Home

Please indicate which adults he/she lives with:

Mother Father Step Mother Step Father

Foster Parents Adopted Parents Grandmother

Grandfather Aunt Uncle

Other _____

Siblings: Names Ages

If applicable, please describe your child's custody agreement:

Has he/she ever been through a traumatic family situation? (Such as divorce, parental loss, separation)

Yes No

What age was he/she? _____

Does he/she seem to have adjusted? _____

Is family life stable at this time? Yes No

How does he/she get along with parents? _____

Siblings? _____

Classmates at school? _____

Playmates at home? _____

Did anyone in father's family have a learning problem?
 Yes No

Who? _____

Did mother or anyone in mother's family have a learning problem?
 Yes No

Who? _____

Do any, or did any of the other children in the family have learning problems?
 Yes No

Who? _____

To what extent? _____

Give a brief description of your child as a person: _____

Additional comments/concerns that you would like the doctor to be aware of:

Report Policies

Would you like copies of any reports? Yes No
Would you like copies sent anywhere? Yes No
Name _____

Address _____

Name _____
Address _____

Name _____
Address _____

(For any others please use the back of this form)

Please sign below to give us permission to release information about your child to the above sources.

Signed _____
Date _____