InfantSEE®

InfantSEE® Confidential Infant History
Assessment Date:
_____/_____/_____

Name: _____ Male ___ Female___ DOB:_____/_____/_____

Home Phone: _____ Hispanic | Caucasian | African American | Native American | Asian | Pacific Islander

Home Address: _____
Street City State Zip Code

Parent(s) or Guardian(s): _____ Adult(s) Occupation: _____

How did you learn about our program? ☐Current patients ☐Referred by friends/family ☐Print Ads ☐Radio Ads ☐Website ☐Story in Newspaper/on TV ☐ Referred by Dr._____

Eye History
Have you ever noticed any of the following happening with your baby's eyes? (please check any that apply)

Eye turn: ☐ in ☐ out ☐ Eyes watering ☐ Eyes red ☐ Swelling around the eyes ☐ White appearance in pupil

Explain any eye concerns noted by observing child: _____

_____

Developmental and Health History

PREGNANCY

Length of pregnancy: _____ weeks List any complications during pregnancy: _____

Other pregnancy issues: _____

DELIVERY

Birth Weight _____ Parents ages at time of birth: Mother _____ Father _____

List any complications during delivery: _____

Was oxygen used? ☐ No ☐ Yes APGAR score at birth: _____ (if known)

MEDICAL

Child's Doctor: _____ Last exam Date: _____ Are immunizations up to date? ☐ Yes ☐ No

Does your baby have any known food or drug allergies? ☐ No ☐ Yes: _____

List ALL medications taken regularly: ☐ None List: _____

List any developmental delays: _____

Check all of the following that your baby can do at this time: ☐ Roll Over ☐ Sit ☐ Crawl ☐ Stand ☐ Walk

Has your baby ever had a high temperature (fever)? ☐ No ☐ Yes, how high? _____

Please list any childhood illnesses your baby has had:

_____ Illness _____Age at the time. Was the illness? ☐ Mild ☐ Moderate ☐ Severe

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List any accidents, eye, or head injuries, and age they occurred:_____

Please list any other conditions we should know about:_____

Family History
Do any family members have: Lazy eye (amblyopia) ☐Yes ☐No Eye turn (strabismus) ☐Yes ☐ No Eye tumor ☐Yes ☐No

Please list any family members with a history of other eye or medical problems. List the relation and type of problem:

I acknowledge that this information is accurate to the extent that I can be certain, and will disclose additional information as necessary. This information can only be used in the management of my child's eyes and vision.

I understand that the InfantSEE® vision assessment is without charge. If further services or treatments are recommended, I may choose any eye care professional to provide those services.

_____ Date: _____/_____/_____
Parent/Guardian Signature

Thank you for carefully completing this confidential questionnaire. This information will allow for a more efficient use of examination time and will contribute to the understanding of infant eye and vision development.

WELCOME TO OUR OFFICE

DR. ANDREA THAU & ASSOCIATES

DOCTORS OF OPTOMETRY
77 PARK AVENUE, NEW YORK, NY 10016
T: (212) 685-2457 F: (212) 685-5989

REFERRED BY: _____

PATIENT NAME: _____ SS#: _____

ADDRESS: _____ APT #: _____

CITY/STATE/ZIP: _____ DATE OF BIRTH: _____

CELL PHONE: _____ HOME PHONE: _____

WORK PHONE: _____ EMAIL: _____

PREFERRED CONTACT: CELL WORK HOME EMAIL MARITAL STATUS: S M SEP D W

EMPLOYER NAME: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ RELATION: _____

CELL PHONE: _____ WORK PHONE: _____

INSURED'S INFORMATION (IF NOT THE PATIENT)

NAME: _____ RELATION: _____

DATE OF BIRTH: _____ SS#: _____

HOME ADDRESS/CITY/STATE/ZIP: _____

WORK PHONE: _____ CELL PHONE: _____ EMAIL: _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ EFFECTIVE DATE: _____

ADDRESS: _____ PHONE: _____

ID#: _____ GROUP #: _____

SECONDARY INSURANCE NAME: _____ EFFECTIVE DATE: _____

ADDRESS: _____ PHONE: _____

ID#: _____ GROUP #: _____

FINANCIAL ARRANGEMENTS AND INSURANCE

- Co-payments, co-insurance, deductibles, all previous balances, non-covered services and amount exceeding your annual maximum are due at the time of service.
- If your insurance requires you to have a referral at the time of the visit, it is your responsibility to obtain the referral. If you do not have one at the time of service, you are required to pay for the visit in full.
- **Returned checks are subject to a $40.00 fee.**
- Routine eye examinations, refractions, contact lens fittings, contact lens evaluations and vision therapy are NOT COVERED by most insurance plans/companies.
- There is a **$50.00 CANCELLATION FEE** for failure to cancel within 24 hours prior to your appointment. Except for visual evaluations/perceptual appointments, there is a **$100.00 CANCELLATION FEE** for failure to cancel these appointments within 48 HOURS prior to your appointment.
- Visual Skills Evaluations and Visual Perceptual Evaluations are NOT COVERED by any insurance plans/companies.

AUTHORIZATION FOR ASSIGMNENT OF BENEFIT

I HEREBY AUTHORIZE DRS. ANDREA THAU, FRAN REINSTEIN, MARILYN VRICELLA, AND/OR ELSA SHEERER TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SREVICES RENDERED BY THEM. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO DRS. ANDREA THAU, FRAN REINSTEIN, MARILYN VRICELLA, AND/OR ELSA SHEERER, AND CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARDS TO MY INSURANCE COVERAGE IS CORRECT. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR THE PAYMENT OF THE ENTIRE BILL IF MY INSURANCE COMPANY DOES NOT COVER ANY SERVICES RENDERED.

PLEASE MAKE SURE YOU HAVE READ THIS DOCUMENT VERY CAREFULLY.

I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

SIGNATURE: _____ **DATE:** _____

OFFICE POLICIES AND FINANCIAL ARRANGEMENTS

- Co-payments, co-insurance, deductibles, all previous balances, non-covered services and/or amount exceeding your annual maximum are due at the time of service.
- If your insurance requires you to have a referral at the time of the visit, it is your responsibility to obtain the referral. If you do not have one at the time of service, you are required to pay for the visit in full.
- Returned checks are subject to a **$40.00 FEE**.
- Routine eye examinations, refractions, contact lens fittings, contact lens evaluations and vision therapy are **NOT COVERED** by most insurance companies.
- There is a **$50.00 CANCELLATION FEE** for failure to cancel within **24 hours** prior to your appointment. Except for visual evaluations and/or perceptual appointments, there is a **$75.00 CANCELLATION FEE** for failure to cancel these appointments within **48 hours** prior to your appointment.
- Visual Skills Evaluations and Visual Perceptual Evaluations are **NOT** covered by any insurance plans/companies.

AUTHORIZATION FOR ASSIGNMENT OF BENEFIT

I HEREBY AUTHORIZE DRS. ANDREA THAU, FRAN REINSTEIN, MARILYN VRICELLA, AND/OR ELSA SHEERER AND/OR TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED BY THEM. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO DRS. ANDREA THAU, FRAN REINSTEIN, MARILYN VRICELLA, AND/OR ELSA SHEERER, CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARDS TO MY INSURANCE COVERAGE IS CORRECT. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR THE PAYMENT OF THE ENTIRE BILL IF MY INSURANCE COMPANY DOES NOT COVER ANY SERVICES RENDERED.

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SIGNATURE _____ DATE _____

ACKNOWLEDGEMENT OF HIPPA RECEIPT

I acknowledge that I received and/or reviewed a copy of Dr. Andrea P. Thau and Associate's Notice of Privacy Practices.

I further consent to the release of my health information for purposes of treatment, payment and health care operations and as authorized by law under the circumstances described in the Notice of Privacy Practices.

Patient Name: _____

Signature: _____

If you are signing as a personal representative for the patient, describe your relationship to the patient and the source of your authority to sign the form:

Relationship to patient: _____ Print name: _____

Source of Authority: _____