CLARENDON VISION DEVELOPMENT CENTER

Dr. Monika Spokas
Developmental Optometrist

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Developmental Optometrist

The information in this history form is critical to the evaluation of your child's vision. This is your opportunity to tell us about all areas in which your child's vision is not serving him or her well.

First Name:____________________ **Last Name:**__________________________ **Date:**_____________

Patient's Date of Birth:_______________________ ☐**Male** ☐**Female**

Grade: __________ **School:** ____

Date of last exam: __________________________

What is the main reason for your child's appointment today? _______________________________________

Has your child worn glasses in the past? .... ☐Yes ☐No

How old was your child when the first pair of glasses was prescribed? ________________________

Does your child wear glasses now? .... ☐Yes ☐No

Does your child wear contacts? .... ☐Yes ☐No

If yes: How often? ____________________ **What brand?**_______________________

Is your child interested in wearing contacts? .... ☐Yes ☐No

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SYMPTOMS QUESTIONAIRE: Please check all of the signs and symptoms that apply to your child and indicate how often they occur:

Never	Sometimes	Often	
☐	☐	☐	Difficulty with reading
☐	☐	☐	Avoids/dislikes reading
☐	☐	☐	Poor reading comprehension
☐	☐	☐	Uses finger or marker to keep place when reading
☐	☐	☐	Loses place, skips, or rereads words and/or letters when reading
☐	☐	☐	Errors in copying from board to paper
☐	☐	☐	Takes a long time to do homework
☐	☐	☐	Seems to know the material but does poorly on tests
☐	☐	☐	Failure to complete work in allotted time
☐	☐	☐	Complains of blurry vision during reading or writing, or when looking up from desk
☐	☐	☐	Reports eyes hurt, burn, or tire when reading
☐	☐	☐	Closes or covers one eye in bright light or during visual tasks
☐	☐	☐	Complains of print moving around or running together
☐	☐	☐	Reports feeling that eyes do not seem to be working together
☐	☐	☐	Complains of headaches associated with visual tasks
☐	☐	☐	Complains of seeing double
☐	☐	☐	Tilts or turns head excessively when doing visual tasks
☐	☐	☐	Eye turns in or out, especially when tired

Never	Sometimes	Often	
☐	☐	☐	Short attention span, easily distracted, or extensive daydreaming
☐	☐	☐	It has been suggested that your child has ADD or ADHD
☐	☐	☐	School performance not up to potential
☐	☐	☐	Experiences unusual fatigue after school
☐	☐	☐	Does not judge distances well, clumsy
☐	☐	☐	Feels dizzy or lightheaded
☐	☐	☐	Experiences car or motion sickness

HEALTH HISTORY: Check any conditions that apply to your child or that run in your family.

Allergies	☐ Child	☐ Family	Lazy eye	☐ Child	☐ Family
Respiratory disease	☐ Child	☐ Family	Turned eye	☐ Child	☐ Family
Cancer	☐ Child	☐ Family	Color “blind”	☐ Child	☐ Family
Diabetes	☐ Child	☐ Family	Light sensitive	☐ Child	☐ Family
Heart problem	☐ Child	☐ Family	Eyestrain	☐ Child	☐ Family
High blood pressure	☐ Child	☐ Family	Dry eyes	☐ Child	☐ Family
Thyroid	☐ Child	☐ Family	Floaters/spots	☐ Child	☐ Family
Migraines/headaches	☐ Child	☐ Family	Flashing lights	☐ Child	☐ Family
Blindness	☐ Child	☐ Family	Retinal detachment	☐ Child	☐ Family
Head trauma	☐ Child	☐ Family	Macular degeneration		☐ Family
Chronic ear infections	☐ Child	☐ Family	Cataracts		☐ Family
			Glaucoma	☐ Child	☐ Family

Other medical problems ______________________________

List illnesses, bad falls, high fevers, etc.:

Illness Age Severity (Mild-Severe) Complications

1. ______________________________
2. ______________________________
3. ______________________________

PARENT/GUARDIAN INFORMATION

First Name: ______________ **Last Name:** ______________ **Relationship to Child:** ______________

Cell Phone Number: ______________ **Home Phone Number:** ______________

Email Address: ______________________________

Address: ______________ **City:** ______________ **Zip Code:** ______________

Vision Insurance: ______________ **Medical Insurance:** ______________

Primary Insurance Holder: ______________________________

Holder’s Date of Birth: ______________ **Last four digits of SSN:** ______________

Payment Policy/HIPAA

Examination and procedure fees are due at the time of service and may be submitted to your major medical insurance carrier. Any applicable co-payments are due at the time of service. If you have insurance coverage for these services or materials, we will submit claims on your behalf. After 30 days, we will expect payment in full if your insurance company has not paid. Any balance 90 days after the date of service will incur a monthly billing service charge of $2.00 or 1.3% (15.6% APR) whichever is greater until the balance is paid in full. Returned NSF checks will be charged a service fee of $35.00.

- I HEREBY AUTHORIZE MY INSURANCE CARRIER TO MAKE PAYMENT DIRECTLY TO CLARENDON VISION DEVELOPMENT CENTER FOR ANY AND ALL SERVICES RENDERED TO ME BY CLARENDON VISION DEVELOPMENT CENTER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.
- I HAVE READ AND AGREE TO THE PAYMENT POLICY STATED ABOVE.
- I HAVE RECEIVED HIPAA POLICY STATEMENT AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

Signature ____ **Date** _________________

Retinal Imaging

We are pleased to provide our patients with an advanced digital retinal exam. It is great for documenting a baseline image for our charts, screen for eye diseases, and improve our ability to view your internal retinal health. A dilated exam may still be recommended by the doctor if a more peripheral view of the retina is indicated. Since insurance only covers retinal photos after eye disease is discovered, the Retinal Imaging Exam is an out of pocket expense. **The fee is $22.00.**

☐ I want to have my retinal health evaluated with Retinal Imaging.

☐ I do not wish to have Retinal Imaging Exam. I understand that I will still have a thorough eye exam with dilation.

Signature ____ **Date** _________________