Dr. Monika Spokas
Developmental Optometrist

Dr. Amber Cumings, FAAO
Developmental/Pediatric/
Neuro-Optometrist

Patient's First Name:________________________________Last Name:________________________________

Today's Date:________________________________Date of last exam:________________________________

Grade:________________________________School: ________________________________

Were you referred to our office? Yes ☐ No ☐

If yes, whom may we thank for this referral? ________________________________Phone: ________________

Address: ________________________________Email Address: ________________________

If not referred, how did you learn about our office? ________________________________

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

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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 currently wear glasses? ....☐ Yes ☐ No

If yes: Do they have Blue Light Protection? ☐ Yes ☐ No

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

If yes: How often? ________________________ What brand?________________________________

If no, is your child interested in wearing contacts? ....☐ Yes ☐ No

On average, how many hours per day does your child spend outside? ________________________________

On average, how many hours per day does your child spend using electronics (iPad, iPhone, computers, etc.) __________

What is currently your child's school/learning set up (e-learning, hybrid, in person)? ________________________

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
☐	☐	☐	Loses place, skips, or rereads words and/or letters when reading
☐	☐	☐	Takes a long time to do homework
☐	☐	☐	Seems to know the material but does poorly on tests
☐	☐	☐	Complains of print moving around or running together
☐	☐	☐	School performance not up to potential
☐	☐	☐	Reports eyes hurt or get tired when doing schoolwork
☐	☐	☐	Complains of seeing double
☐	☐	☐	Eye turns in or out, especially when tired
☐	☐	☐	Short attention span, easily distracted, or extensive daydreaming

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Never	Sometimes	Often	
☐	☐	☐	It has been suggested that your child has ADD or ADHD
☐	☐	☐	Does not judge distances well, clumsy
☐	☐	☐	Experiences car or motion sickness

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

Condition			Condition		
Allergies	☐ Child	☐ Family	Lazy eye	☐ Child	☐ Family
Respiratory disease	☐ Child	☐ Family	Crossed eyes	☐ Child	☐ Family
Cancer	☐ Child	☐ Family	Color “blind”	☐ Child	☐ Family
Diabetes	☐ Child	☐ Family	Nearsighted	☐ Child	☐ Family
Heart problem	☐ Child	☐ Family	Farsighted	☐ Child	☐ Family
			Refractive Eye Surgery (Lasik, PRK)	☐ Child	☐ Family
High blood pressure	☐ Child	☐ Family	Retinal detachment	☐ Child	☐ Family
			Blindness	☐ Child	☐ Family
High Cholesterol	☐ Child	☐ Family	Macular degeneration		☐ Family
Thyroid	☐ Child	☐ Family	Cataracts		☐ Family
Migraines/headaches	☐ Child	☐ Family	Glaucoma	☐ Child	☐ Family
Head Trauma/ Concussion	☐ Child	☐ Family			
			ADD/ADHD	☐ Child	☐ Family
Epilepsy/Seizures	☐ Child	☐ Family	Learning Disability	☐ Child	☐ Family
Chronic ear infections	☐ Child	☐ Family	Dyslexia	☐ Child	☐ Family

Medications currently using, including vitamins and supplements:

1. ______________________________ Condition: ____________________

2. ______________________________ Condition: ____________________

3. ______________________________ Condition: ____________________

4. ______________________________ Condition: ____________________

5. ______________________________ Condition: ____________________

Does your child have any allergies to any medications?.. ☐ Yes ☐ No

If yes: What medication? ____

760 Pasquinelli Drive, Suite 300
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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 $35.00.**

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

☐ I do not wish to have Retinal Imaging Exam for my child. I understand that a thorough eye exam with dilation will be performed.

Signature ____ Date ____________

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 for you. However, we are not liable for collecting your claim. 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.

THE OFFICE'S COMPLETE HIPAA POLICY STATEMENT IS AVAILABLE FOR REVIEW UPON REQUEST.

- I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW THE OFFICE'S HIPAA POLICY STATEMENT.

Signature of Responsible Party ____ Date ____________

APPOINTMENT CANCELLATION / NO SHOW POLICY

Thank you for trusting your medical care to Clarendon Vision Development Center. When you schedule an appointment with Clarendon Vision Development Center, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

- Please provide our office a 24-hour notice if you need to reschedule or cancel your appointment.
- A "No-Show", "No-Call" or missed appointment, without proper 24-hour notification, will be charged a $150 fee. In the event of an emergency where prior notice could not be given, consideration will be given, and a one-time exception may be granted.
- If you are more than 10 minutes late for your appointment, the appointment may be cancelled and rescheduled.

- If a reminder call or message from our office is not received by the patient, the cancellation policy still remains in effect.
- The cancellation/no show fees are the sole responsibility of the patient and must be paid in prior to the patient's next appointment.
- This fee is not billable to your insurance.

If you have any questions regarding this policy, please let our staff know and we will be glad to answer them.

I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.

Signature of Responsible Party ____ Date ________________

Thank you for carefully completing this questionnaire. The information you supplied will allow us to provide a more comprehensive evaluation and better meet your child's specific visual needs.

If you have any questions, please contact our office at (630) 323-7300 prior to your appointment.