



Maumee Center for Eyecare

Vista Professional Center
1657 Holland Road
Maumee, OH 43537
Phone: (419) 891-1023

DEAR PARENTS:

Your child's vision develops in conjunction with such other functions as walking and talking and is affected by certain illness as well his/her family history. Therefore, your thorough answers to this form will aid us in determining how your child's vision has developed as well as permitting us to utilize all of the office time for a complete optometric examination.

Child's full name: _____ Nickname: _____
Address _____ City _____ Zip _____
Home Ph. # _____ Birth date _____ Age now _____ Grade _____
School _____ Teacher's name _____
Parents' names _____
Step-parents/Guardian (if applicable) _____
Work Ph. # _____ Cell Ph. # _____
Parents' occupations: _____

PRESENT SITUATION:

1) Does your child seem to have any visual difficulty? _____

2) Does your child experience any of the following:

- | | | | |
|------------------------------|------------------------------|-----------------------------|-------------|
| a) headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ |
| b) blurred vision | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ |
| c) double vision | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ |
| d) eyes "hurt or seem tired" | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ |

OCCULAR HISTORY:

- | | |
|---|---|
| a) <input type="checkbox"/> holding reading close | i) <input type="checkbox"/> excessive eye rubbing |
| b) <input type="checkbox"/> uses fingers when reading | j) <input type="checkbox"/> getting lost in books |
| c) <input type="checkbox"/> reverse words | k) <input type="checkbox"/> tilting head when reading |
| d) <input type="checkbox"/> skips words | l) <input type="checkbox"/> bumping into objects |
| e) <input type="checkbox"/> closes or covers one eye | m) <input type="checkbox"/> poor general coordination |
| f) <input type="checkbox"/> frowning or squinting | n) <input type="checkbox"/> large pupils in bright lights |
| g) <input type="checkbox"/> eyes frequently reddened | o) <input type="checkbox"/> bothered by light |
| h) <input type="checkbox"/> frequent styes | p) <input type="checkbox"/> "car sickness" |

ACADEMIC HISTORY:

Age at time of entrance into Kindergarten _____
Age at time of entrance into First Grade _____
Child likes school yes no unknown
Child likes teacher yes no unknown
Repeated grade/s _____

Explain any difficulty with school _____

List subjects, which seem difficult for your child _____

List reasons for which child is having remedial work _____

Child likes to read? ___ Yes ___ No ___ Sometimes

DEVELOPMENTAL HISTORY:

Pregnancy: ___ full term ___ premature

Birth: ___ normal ___ caesarean

Complications before, during or immediately following delivery: _____

Crawled: ___ yes ___ no On all fours: ___ yes ___ no

Walked at age: ___ months ___ unknown

Speech: First words at age ___ sentences ___ unknown

When fatigued child: ___ sags ___ becomes irritable ___ becomes excited

MEDICAL HISTORY:

List all past illnesses and significant injuries: _____

MEDICATIONS:

List all current medications: _____

HEALTH AT PRESENT:

___ good ___ fair ___ poor

PREVIOUS VISUAL HISTORY:

Examination date: _____ Results: _____

List all family members who have had visual attention and why: _____

List any unusual family eye conditions: _____

Give a brief thumbnail description of child's personality: _____

INSURANCE INFORMATION: We will need to make copies of your insurance cards.

Major Medical _____ Policy #/member name _____

Secondary Ins. _____ Policy #/member name _____

Vision Ins. _____ Policy #/member name _____

DOB and SSN of policyholder _____

Referred by: _____

Thank you

Please visit our web site at: www.drthomascable.com

THOMAS A. CABLE, O.D., INC.
1657 HOLLAND RD. STE. D
MAUMEE, OH. 43537
(419)891-1023
FAX: (419)891-1138

STUDENT _____ D.O.B. _____

Behavioral Indicators of Vision Performance Difficulties

VISUAL

- _____ Difficulty with or avoidance of tasks requiring concentration, memory, reading or problem solving
- _____ Poor memory or concentration, trouble with spelling, vocabulary and grammar
- _____ Inability to complete work during a given time frame
- _____ Complains of headache associated with near work
- _____ Complains of double vision or of blurry vision (far or near)
- _____ Covers or closes one eye when reading or doing near tasks
- _____ Complains of discomfort or inability to learn tasks demanding consistent attention to fine detail
- _____ Tilts head extremely or works to one side of desk
- _____ Either eye turns in or out
- _____ Rubs eyes or forehead frequently

VISUAL-MOTOR

- _____ Poor physical or athletic performance (particularly poor spatial awareness)
- _____ Holds reading material very close to face
- _____ Writes in small, cramped style
- _____ Makes frequent errors in copying
- _____ Complains of words or letters jumping around
- _____ Loss of place while reading
- _____ Uses finger to keep place while reading
- _____ Handwriting is sloppy
- _____ Easily frustrated trying to draw figures

READING/LANGUAGE

- _____ Reverses letters or words
- _____ Omits letters/words when reading or writing
- _____ Poor spelling
- _____ Tires easily when reading
- _____ Performs below ability level for obvious reason

ATTENTION

- _____ Trouble sitting still, fidgets frequently
- _____ Poor attention to reading
- _____ Responds to directions poorly
- _____ Behavior problems (particularly those related to frustration in the learning environment)
- _____ Displays tiredness or lethargy during the school day
- _____ Indifference to classroom and/or academic performance
- _____ Trouble remembering or relating to material that is read

TEACHER _____ GRADE _____
SCHOOL _____
PHONE _____

**MAUMEE CENTER FOR EYECARE
PATIENT FINANCIAL INFORMATION SHEET**

Name of Patient: _____ **DOB** _____

Name of Insured: _____ **DOB** _____

If NO Insurance Card is Available please supply the Insurance Carrier and ID#

Name of Insurance Carrier: _____

ID# _____ **Policy#** _____

Insurance Card Copied: _____ Yes _____ No _____ No Card

Authorization and Release:

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent if minor

Date

HIPAA PRIVACY PRACTICE ACKNOWLEDGEMENT

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such care to third party payers and/or other healthcare practitioners.

I accept release of records:

Signature

Date

I decline release of records:

Signature

Date

Office Policy
Thomas A. Cable, O.D. & Associates

New patients and current patients:

Thank you for choosing us as your vision care provider. We are committed to your treatment being successful. Please understand that payment of services is considered a part of your treatment. This letter is to help us, as well as our patients understand our office and financial policies which we require you to read and sign prior to any future treatment. In order for us to keep our fees lower we need to obtain control of very costly monthly billing.

All patients must complete our Information and Insurance form before seeing the doctor.

Full payment is due at time of service unless otherwise arranged prior. We accept cash, checks, Visa, MasterCard & Discover.

Invoices are due upon receipt. If your account must be sent for collection activity, you may be asked to seek vision care elsewhere. In the event you are sent to collections we reserve the right to charge you the collection fee.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. They vary from one insurance company to another.

Minor Patients:

The adult accompanying a minor is responsible for full payment. We cannot do third party billing. If this is a divorce or custody situation we will bill the adult accompanying the minor. We no longer bill the non-present adult this is your responsibility.

Contact Lens Return Policy:

Unopened contact lenses must be returned within 30 days of purchase for credit.

Missed Appointments:

Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments. There are patients that would be willing to take the appointments at short notice. It is very costly for the doctor and staff to have wasted down time without patients. If more than one appointment is missed we may not reschedule.

I have read the office policy. I understand and agree to this new policy:

X _____ Date: _____

Thank you,

Thomas A. Cable, O.D.