KRAMER FAMILY VISION INFORMATION FORM (FOR PTS ↓18)

Name____Date of Birth______________
First Name MI Last Name

Address____SS#______________
Street City State Zip

Phone: ☐Home ______________ ☐Cell/Work#1______________ Contact Name______________

☐Home ______________ ☐Cell/Work#2______________ Contact Name______________

Grade______________ School______________ Teacher______________
Race/Ethnicity: ☐ African American ☐ Asian ☐ Caucasian/White ☐ Hispanic/Latino ☐ American Indian ☐ Other

HEALTH HISTORY

Average daily computer use:________ hours

Date of last eye exam ______________ Doctor/Place______________
Has he/she ever worn glasses? ☐Yes ☐No Contact Lenses? ☐Yes ☐No Type:______________

HAS **THE CHILD** EVER BEEN TREATED OR DIAGNOSED WITH ANY OF THE FOLLOWING?

☐ Eye Surgery
☐ Glaucoma
☐ Cataracts
☐ Macular Degeneration
☐ Eye Injury
☐ Retinal Problems
☐ Blindness
☐ Strabismus/Crossed Eye
☐ Amblyopia/Lazy Eye

DOES **THE CHILD** EXPERIENCE ANY OF THE FOLLOWING?

☐ Blurred Vision
☐ Double Vision
☐ Dry Eye
☐ Burning
☐ Itching
☐ Tearing
☐ Flashes of Light
☐ Floaters
☐ Eye Pain
☐ Light Sensitivity
☐ Redness
☐ Unexplained Headache

IS THERE A **FAMILY** HISTORY OF THE FOLLOWING? (please indicate relation next to condition: M, F, GM, GF, B, S)

☐ Glaucoma __________
☐ Blindness __________
☐ "Lazy" Eye __________
☐ Retinal Problems __________
☐ Macular Degeneration __________
☐ Cataracts before age 40__________
☐ Diabetes __________
☐ Cancer __________
☐ Heart Disease __________

Date of last routine health appt ______________ Name of Regular Physician ______________

HAS **THE CHILD** EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?

☐ Currently Ill
☐ Cardiovascular Problems
☐ Hypertension
☐ Heart Surgery
☐ Heart Attack
☐ Pace Maker
☐ High Cholesterol
☐ Ear/Nose/Throat Problems
☐ Respiratory Problems
☐ Gastrointestinal Problems
☐ Hepatitis A B C
☐ Arthritis: Osteo / Rheumatoid
☐ Muscle Pain or Disorders
☐ Fibromyalgia
☐ Skin Disorders
☐ Stroke/Neurological
☐ Anxiety
☐ Depression
☐ Diabetes (Type 1 or 2)__________
(Date of Diagnosis)__________
☐ Thyroid Problem: Hypo / Hyper /__________
☐ Anemia
☐ Sickle Cell Anemia
☐ Blood Clot/Bleeding
☐ HIV/AIDS
☐ Tuberculosis
☐ Cancer (type/when)__________
☐ Other__________
☐ Currently Pregnant
How far along?__________

DOES THE CHILD USE TOBACCO PRODUCTS? ☐Never Smoked ☐Everyday Smoker ☐Occasional Smoker ☐Smokeless

DOES THE CHILD HAVE ANY SPECIAL NEEDS? ☐Yes ☐No ______________

IS THE CHILD CURRENTLY ENROLLED IN: ☐Auditory/Occupational/Physical Therapy ☐ Resource/Speech/Tutoring

USE ANY EYEDROPS? (include over the counter)______________PREFERRED PHARMACY______________

LIST ALL MEDICATIONS/SUPPLEMENTS & DOSING (or provide medication list to receptionist):______________

____

LIST ALL ALLERGIES: (include allergies to MEDICINE or ENVIRONMENTAL SUBSTANCES):______________

HOW DID YOU HEAR ABOUT US?
☐ Phonebook ☐ Newspaper ☐ Internet ☐ Friend/Family______________ ☐ Other______________

PLEASE CONTINUE ON THE BACK SIDE

Insurance Information: All charges not covered by the insurance carrier will be the responsibility of the patient.

Vision insurance will cover routine services and glasses--benefits only covered once per year (or every 2 years).
Medical insurance MAY cover the examination if there is a medical problem with the eyes.

Vision Insurance: Company______________________________ Relationship to Insured__________________

Policy Holder's Name_______________________________________Policy Holder's Date of Birth________________

Policy Holder's Social Security #________________________________(This is only necessary if you do not have a vision card)

Medical Insurance:

Primary Insurance Company_________________________________ Relationship to Insured___________________

Policy Holder's Name_______________________________________Policy Holder's Date of Birth________________

Secondary Insurance Company______________________________ Relationship to Insured___________________

Policy Holder's Name_______________________________________Policy Holder's Date of Birth________________

I attest that the information included on this form is correct to the best of my knowledge

I understand the HIPAA Privacy Policy as stated below and I understand that a copy of the full privacy practices of Kramer Family Vision may be furnished upon request.

Legal Guardian Signature:____ Date:________________

Summary of HIPAA NOTICE OF PRIVACY PRACTICES

WE MAY USE YOUR INFORMATION FOR TREATMENT PURPOSES BY:

- **Setting up an appointment or confirmation of an appointment already made (including reminder postcards and messages left on an answering machine).**
- **Testing or examining your eyes; Prescribing glasses, contact lenses, or eye medications (and faxing them to be filled) ; showing you vision therapy or low vision aids .**
- **Referring you to another doctor or clinic for eye care, surgery, low vision aids, or vision therapy services or getting copies of your health information from another professional.**

WE MAY USE YOUR INFORMATION FOR PAYMENT PURPOSES BY:

- **Asking about health and vision care plans or other sources of payment.**
- **Preparing and sending bills or claims.**
- **Collecting unpaid amounts (ourselves or through a collection agency or attorney).**

WE MAY USE YOUR INFORMATION TO MAINTAIN THE HEALTH CARE OPERATIONS OF OUR OFFICE BY:

- **Financial or billing audits, Internal quality assurance, Personnel decisions, Participation in managed care plans, Defense of legal matters, Business planning, or Outside storage of records**

***We routinely use your health information inside our office for these purposes without any special permission.**
***If we need to disclose your health information outside our office for these reasons, we will ask you for special written permission.**

USES/DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION:

We are obligated to release your information in the following circumstances:

- **When mandated by state or federal law that certain health information be reported.**
- **Disclosures to governmental authorities regarding victims of suspected abuse, neglect, or domestic violence.**
- **Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.**
- **Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime.**
- **Unless you object, we will also share relevant information about your eye care with your family or friends who are helping you with your eye care.**