OFFICE USE ONLY:		
Dr: _____	ID #: _____	☐ Fundus Photos
Time: _____	INS: _____	☐ External Photos
Exam Type: _____	Copay: _____	Visual Field ☐ 10-2 ☐ 24-2
ROUTINE / MEDICAL	OPTOS: YES NO	☐ OCT (o) ☐ OCT(m)
RTC: ☐ Annual ☐ GLC ☐ IOP ☐ F/U ☐ _____		DFE Time: _____

Maine Mall Eye Care

New Patient PEDIATRIC Paperwork

Name: _____ **M F**
Preferred Name: _____
Race/Ethnicity: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Social Security #: _____
Birth Date: _____
Grade/School: _____

Home Phone: _____
Cell Phone: _____ **Text: Y N**
Work Phone: _____
Email: _____
Preferred Method of Contact: _____
Pediatrician / Practice: _____
Last Medical Exam: _____
Last Eye Exam (mm/yy): _____

PARENT(S) CONTACT INFORMATION:

Name(s): _____ **Address :** _____
(if different from patient) Street City State Zip
Contact phone: _____

The child lives with: _____ **Child was brought in today with:** _____
Parent/Guardian Name

Is there tobacco used in/around the household? ☐ No ☐ Yes

VISUAL HISTORY

Please mark if YOUR CHILD currently has, or has ever had complaints of:

☐ Worn eyeglasses	☐ Worn an eyepatch	☐ Headaches	☐ Used eyedrops
☐ Blurry vision	☐ Has an eye that drifts in/out	☐ Poor gross motor skills	☐ Red / Painful eyes
☐ Avoids Reading	☐ Reverses words/letters	☐ Poor fine motor skills	☐ Frequent Styes
☐ Words/letters moving	☐ Complains of seeing double	☐ Short attention span	☐ Rubs eyes
☐ Sits close to the TV	☐ Often closes/covers an eye	☐ Blinks excessively	☐ Watery eyes
☐ Hard to see distance	☐ Holds objects very close	☐ Loses place while reading	

☐ Injury to eyes If yes, explain: _____
☐ Any visual problems If yes, explain: _____
☐ Lazy eye (amblyopia) If yes, explain: _____
☐ Eye turn (strabismus) If yes, explain: _____
☐ Eye tumor If yes, explain: _____

Any Other Health Conditions Not Listed Above: _____

Concerns for today's visit? _____

LEISURE TIME ACTIVITIES

Does your child watch TV? ☐ Yes ☐ No Viewing distance? ☐ Very close to face ☐ Normal range ☐ Far

How often? ☐ >1 hour/day ☐<1 hour/day ☐ Few times/week ☐ Few times/month

Does your child use the computer/tablet/play video games? ☐ Yes ☐ No

Viewing distance? ☐ Very close to face ☐ Normal range ☐ Far

How often? ☐ >1 hour/day ☐<1 hour/day ☐ Few times/week ☐ Few times/month

What other activities occupy your child's leisure time? _____

Are there any activities your child would like to participate in, but does not? ☐ Yes ☐ No

If yes, please explain: _____

HEALTH HISTORY

Has your child ever had any other following:

☐ Blood transfusions ☐Measles (Rubella) ☐Meningitis

☐ Chicken pos (Varicella) ☐ Mumps ☐ Contusions

☐ Hospitalizations If yes, explain: _____

☐ Other illness If yes, explain: _____

Medications: _____

☐ **No Medications**

Supplements/Vitamins: _____

Allergies: _____

☐ **No Drug Allergies**

FAMILY HISTORY

Please check off each item as it pertains to the patient's parents, grandparents, siblings, children (living or deceased)

	If yes, state relation		**If yes, state relation**
Glaucoma	☐ Yes _____	Diabetes	☐ Yes _____
Macular Degeneration	☐ Yes _____	Hypertension	☐ Yes _____
Blindness	☐ Yes _____	Cancer (type)	☐ Yes _____
Crossed / Lazy Eye	☐ Yes _____	Cardiovascular	☐ Yes _____
Retinitis Pigmentosa	☐ Yes _____	Thyroid Disease	☐ Yes _____
Retinal Detachment	☐ Yes _____	Lupus	☐ Yes _____
Sjögren's Syndrome	☐ Yes _____		

Other FHx (List Issue/Relation) ☐ Yes _____

AUTHORIZED CONTACTS

Please list the names of anyone you would like to grant permission for us to talk to regarding your appointments and/or medical history. We are unable to discuss this information with anybody other than yourself without express consent. (<u>This will remain valid until it is requested that they be removed.</u>) *This excludes those holding Power of Attorney, or the parent/guardian of someone aged 18 or younger.*

Name/Relation: _____ Has access to: ☐ Appt info only ☐ Health & Appt info

Maine Mall Eye Care Policies & Procedures

Section 1. Financial Responsibility & Vision Care and Medical Insurance

By signing this form, you agree to pay the portion of the bill which is either not covered or denied by the insurance company. If you do not pay this amount, you are responsible for any collection fee assessed. MMEC reserves the right to refuse to submit claims to insurance companies we are not in network with. **It is your responsibility to know your insurance policy coverage and benefits. It is possible that our staff will not have access to all details of your benefits until the insurance claim has been submitted and processed**.
You are also responsible for obtaining any referrals required by your insurance company to be seen. When a medical diagnosis or medical condition is present that affects your eyes we must file the claim with your medical insurance, and the co-pays and deductibles for that insurance will apply. Vision insurances cover ONLY routine services/examinations and/or materials, any condition outside of routine can be deemed as medical and will be billed accordingly.
Additional visits to our practice following an initial visit are subject to additional charges (excluding contact lens checks and/or prescription checks within the first 90 days after the initial exam).
We offer a self-pay discounted rate of $195 for patients paying out of pocket ON THE SAME DAY OF SERVICE. This does NOT extend to patients whose provide insurance information after the date of service; at which point the full examination rate will be applicable.

Section 2. Patient Receipt of Privacy Notice

I hereby affirm that I have received a copy of the *Notice of Privacy Practices* from Maine Mall Eye Care. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this Notice from my healthcare provider. I understand that **my signature on this acknowledgement only signifies that I have received a copy** of the *notice* and does not legally bind or obligate me in any way. I understand that I am entitled to receive a copy of the *Notice of Privacy Practice* from my healthcare provider, whether I sign this acknowledgement or not.

Section 3. Contact Lens and Glasses Prescription information.

An annual contact lens exam and fitting are required to **renew** your prescription for contact lenses. The fitting fee is not covered by insurance. ***Contact lens follow ups are included with the fitting fee for 3 months following the initial exam date. Therefore, we recommend that annual renewal of contact lenses (contact lens fittings) be done AT the time of your annual visit. After such time, any subsequent visits and/or adjustments made to the contacts will require another exam.***
Training is required for all first-time lens wearers and there is an additional fee for this procedure. Your contact lenses are a medical device that can only be dispensed with a valid prescription. In office contact trials are for patients with appointments. If you run out of contacts before your scheduled contact lens exam, we can offer you trials ONE TIME ONLY. ***Unopened, unmarked contact lens boxes purchased from our office can be exchanged within 3 months of the purchase date.***
Glasses prescription follow ups are included in the cost of the exam fee for **three months from the exam.** After 3 months, a new exam is required.

Section 4. Maine Mall Eye Care Missed Appointment Policy

If you do not present to the office for your appointment at the designated time, this will be a “No-Show/Missed” appointment.
After the first “No-Show/Missed” appointment, you will receive a call or a letter reminding you of our "No-Show/Missed Appointment" policy. Our office staff will help you reschedule this appointment if needed.
If you have 2 “No-Show/Missed” appointments, you will receive a letter from our office advising you of the second no-show/missed appointment occurrence and the potential for a third occurrence will prevent you from scheduling any future appointments at our office.
If you have 3 "No-Show/Missed" appointments, you will receive a notice from our office stating that you may not be able to schedule any future appointments with our office. **You will receive a bill for a $35.00 missed appointment fee for any missed appointment.**

Section 5. IF PATIENT IS A MINOR (17 years old or younger) OR HAS A POA, THIS SECTION IS REQUIRED:

Guarantor's Name: (**REQUIRED IF PATIENT IS A MINOR**) _____

Relationship to Patient: _____

Guarantor's Address _____

Guarantor’s Cell Phone Number: _____

By signing this form, you are indicating that you have read, understand, and agree to the above information.

Signature: _____ Date: _____

Name (printed): _____