Appointment Checklist

- Current health insurance information, including ID card
- Photo identification
- Completed registration forms. They may be filled in online but must be printed.

  The check-in time is when the patient presents completed registration forms, not when the patient

  arrives. Please arrive 20-30 minutes prior to the appointment time if forms need to be completed

  in the office.
- Referral/Authorization (if required by your insurance)
- List of all medications your child takes (including strengths/dosages)
- Pharmacy information (name, address, and phone number)
- Please bring a translator, if necessary.
- Copays and other out of pocket expenses will be collected at check-in. We accept cash, check, and most credit cards.
- Glasses and/or contact lenses (Please bring contact lens boxes with lens information.)
- If relevant, please bring records pertaining to your child's condition such as relevant MRI/CT results, labwork, operative reports, etc.
- We require a parent or guardian accompany the child to the initial visit.
- We ask that you not bring siblings or other family members that are not being seen to the appointment as they may distract your child during the examination.
- Toys/activities for your child to play with as some appointments can take 2-3 hours.
- Please allow sufficient travel time. If you arrive more than 20 minutes after your scheduled appointment time, you may be asked to reschedule.

Ideal EyeCare * 6028 S. Fort Apache Road, Suite 101 * Las Vegas, NV 89148

Ideal EyeCare Registration Form-Pediatric

Name (Last, First, MI):			Date of Birth: Age:
SSN:	Sex:	Gender:	Preferred Pronouns:
Home Phone:		Email:	
Cell Phone:		May we contact you by:	□ Phone □ Text □ Email □ All
			(check preferred contact methods)
Street Address:			Apt/Unit #:
City, State, Zip Code:			
Race: □ Alaskan □ American Indian □ Asian □ Black □ Hawaiian/Pac Islander □ Spanish/Latin □ White □ Other_____			
Ethnicity:		Preferred Language:	
Pharmacy:		Phone #:	Cross Streets:
Referring Physician:			Phone #:
Primary Care Physician:			Phone #:
Emergency Contact:			Phone #:

Financial Responsibility for Dependent Patients: Parent/Guardian Information

Parent's Name:		Home Phone:	**Check One:** □ Natural Parent □ Stepparent
Date of Birth:	Age:	Mobile Phone:	□ Foster Parent □ Legal Guardian
Occupation:		Work Phone:	□ Adoptive Parent □ Other _____
SSN:		Email:	
Street Address:			Employer:
City, State, Zip Code:			
Parent's Name:		Home Phone:	**Check One:** □ Natural Parent □ Stepparent
Date of Birth:	Age:	Mobile Phone:	□ Foster Parent □ Legal Guardian
Occupation:		Work Phone:	□ Adoptive Parent □ Other _____
SSN:		Email:	
Street Address:			Employer:
City, State, Zip Code:			

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Insurance Name:	Insurance Name:
ID #:	ID #:
Group #:	Group #:
Subscriber Name:	Subscriber Name:
Relationship to patient:	Relationship to patient:
Subscriber Date of Birth:	Subscriber Date of Birth:

HIPAA Approved Contacts

Name	Phone:	Relationship:	Date of Birth:
Name	Phone:	Relationship:	Date of Birth:
Name	Phone:	Relationship:	Date of Birth:

Patient's or Authorized Person's Signature

I understand that even if Ideal EyeCare is contracted with my insurance plan, I am ultimately responsible for payment of both covered and non-covered services performed during the course of my child's treatment. I understand that any payment collected today is an *estimate* of my total liability and additional monies may still be owed once my insurance plan has processed the claim. I request payment of authorized benefits by my insurance plan be made to Ideal EyeCare for services rendered and request that Ideal EyeCare submit claims for payment for those services on my behalf to my insurance carrier. I authorize the release of any/all medical information to the insurance carrier or its agents to allow for benefit or claim determination. I understand that if Ideal EyeCare does not participate with my insurance plan or if I have elected to receive care outside of my insurance coverage, I am assuming financial responsibility for all services rendered and no claim will be filed to my insurance company on my behalf. I certify that the information provided above is complete and accurate and assume any and all financial liability caused by omissions or inaccuracies.

Parent/Guardian Signature: _____ **Date:** _____

We also provide adult eye care and aesthetic services. □ **Yes**, I would like more information

Ideal EyeCare OPHTHALMOLOGY

MEDICAL HISTORY QUESTIONNAIRE-PEDIATRIC

Name:_____ **Date of Birth:**_____ **Today's Date:** _____
Pediatrician: _____ **Referring Doctor/Specialist:** _____
What is the reason for today's visit?_____
Patient Height:_____ **Patient Weight:** _____
Does your child wear glasses? □ Yes □ No **Does your child have a back up pair of eyewear?** □ Yes □ No
Does your child need a new pair of eyewear? □ Yes □ No **Is your child interested in contact lenses?** □ Yes □ No

Allergies	**Reaction**	**Severity**
_____	_____	□ Mild □ Moderate □ Severe
_____	_____	□ Mild □ Moderate □ Severe
_____	_____	□ Mild □ Moderate □ Severe
_____	_____	□ Mild □ Moderate □ Severe

Is your child *currently* experiencing any of the following: (Please mark all that apply and provide detail)

□ Abnormal Head Position_____
□ Blurry/Decreased Vision _____
□ Double Vision _____
□ Droopy Eyelid(s) _____
□ Dry Eyes _____
□ Eye Injury _____
□ Eye Pain/Burning _____
□ Eye Misalignment _____
□ Flashes/Floaters _____
□ Glare/Light Sensitivity_____
□ Growth/Bump in Lid _____
□ Headaches _____
□ Itchy Eyes/Eyelids _____
□ Red Eyes _____
□ Watery Eyes _____
□ Other _____
□ **NONE** (The patient is not experiencing any of these symptoms)

Past Ocular History: (Please mark all that apply and provide detail)

□ Amblyopia (Lazy Eye)_____
□ Aphakia _____
□ Astigmatism _____
□ Cataracts _____
□ Diabetic Retinopathy_____
□ Dry Eyes _____
□ Glaucoma _____
□ Hyperopia (Farsightedness)_____
□ Iritis/Uveitis _____
□ Keratoconus_____
□ Macular Degeneration (Dry)_____
□ Macular Degeneration (Wet)_____
□ Myopia (Nearsightedness)_____
□ Optic Neuritis_____
□ Retinal Detachment_____
□ Other _____
□ **NONE** (The patient has never had any of these conditions)

Past Ocular Surgeries: (Please mark all that apply and provide detail)

□ Blepharoplasty_____
□ Cataract Surgery_____
□ Corneal Transplant _____
□ Foreign Body Removal_____
□ LASIK/PRK/RK_____
□ Ptosis Repair_____
□ Punctal Plugs_____
□ Retinal Laser_____
□ RD Repair_____
□ Strabismus Surgery_____
□ Glaucoma Surgery_____
□ Vitrectomy_____
□ Other_____
□ **NONE** (The patient has never had eye surgery)

Ocular Significant Illnesses/Conditions: (Please mark all that apply and provide detail)

□ Bell's Palsy_____
□ Brain Tumor_____
□ Cancer _____
□ Chicken Pox/Shingles_____
□ Diabetes _____
□ Type I □ Type II □ Diet-Controlled □ Insulin Use □ Oral Medication(s) Use
□ Headaches/Migraines_____
□ Herpes Simplex_____
□ Histoplasmosis _____
□ HIV/AIDS _____
□ Hypertension_____
□ Meningitis _____
□ Myasthenia Gravis_____
□ Multiple Sclerosis_____
□ Marfan syndrome_____
□ JIA/JRA_____
□ Stroke/TIA_____
□ Syphilis_____
□ Thyroid disease_____
□ Other:_____
□ **NONE** (The patient has never had any of these conditions)

Please continue on the back side of this page →

Other Past Medical Conditions/Illnesses: (Please mark all that apply and provide detail)

□ Anemia_____
□ Asthma_____
□ Autism_____
□ ADD/ADHD_____
□ Depression_____
□ Eczema_____
□ Hearing Loss_____
□ Cerebral Palsy_____
□ Kidney Disease_____
□ Lung Disease_____
□ MRSA_____
□ Developmental Delays_____
□ RSV_____
□ Psychiatric Disorder_____
□ Seizure Disorder_____
□ Irregular Heartbeat (Arrhythmia)_____
□ Other_____
□ Other_____
□ **NONE** (The patient has never had any of these conditions)

Family History (Please mark all that apply and circle which family member) □ **Unknown Family History**

□ Blindness	Parent / Sibling / Maternal Grandparent / Paternal Grandparent / Other:_____
□ Cataracts	Parent / Sibling / Maternal Grandparent / Paternal Grandparent / Other:_____
□ Glaucoma	Parent / Sibling / Maternal Grandparent / Paternal Grandparent / Other:_____
□ Strabismus	Parent / Sibling / Maternal Grandparent / Paternal Grandparent / Other:_____
□ Amblyopia (Lazy Eye)	Parent / Sibling / Maternal Grandparent / Paternal Grandparent / Other:_____
□ Macular Degeneration	Parent / Sibling / Maternal Grandparent / Paternal Grandparent / Other:_____
□ Diabetes	Parent / Sibling / Maternal Grandparent / Paternal Grandparent / Other:_____
□ Cancer	Parent / Sibling / Maternal Grandparent / Paternal Grandparent / Other:_____
□ Heart Disease	Parent / Sibling / Maternal Grandparent / Paternal Grandparent / Other:_____
□ Hypertension	Parent / Sibling / Maternal Grandparent / Paternal Grandparent / Other:_____

Systemic Medications: (Please list all OTC/supplements/Prescription Medications taken inc dosage/strength)

□ Please see Medication List (separate page) □ **NONE** (The patient does not take any medications (OTC or RX)/vitamins/supplements)

Ocular Medications: (Please list **all** OTC/supplements/Rx medications, inc. dosage/strength-or attach a separate page)

General Surgeries/Operations: (Please include dates performed and request separate page if necessary)

□ Please see Procedure List (separate page) □ **NONE** (The patient has never had any type of surgery or procedure)

Social History:

Does anyone in the household use tobacco (cigarettes, vape, etc.)? □ Yes □ No
If yes: □ Traditional cigarettes □ Vape/E-cigarettes □ Other:_____ □ Indoors □ Outdoors □ In the car
Drug use by mother during pregnancy? □ Yes □ No Substance used: _____
Child resides with: □ Both parents □ Mother □ Father □ Grandparent(s) □ Foster parent □ Other:_____
Child attends: □ School □ Daycare □ Homeschool

Birth History:

Gestational Age: _____ weeks Weight:_____lbs ____ oz □ Vaginal Delivery □ Cesarean section
Oxygen administered neonatally? □ Yes □ No Duration:_____ Delivered via: □ Nasal cannula □ Mask
Delivery details: □ Forceps used □ Suction used □ Nuchal cord (#_____) □ Other:_____

Review of Systems: (Please review the separate list of conditions, signs, and symptoms and record any that apply to your child here. You may write them here or mark them directly on a corresponding sheet.)

□ Ears, Nose, Throat_____
□ Cardiovascular_____
□ Respiratory_____
□ Gastrointestinal_____
□ Genitourinary_____
□ Integumentary (Skin)_____
□ Cancer _____
□ Musculoskeletal_____
□ Neurological_____
□ Hematologic/Lymphatic (Blood)_____
□ Endocrine_____
□ Allergic/Immunologic_____
□ Genetic Disorders_____
□ Infectious Disease_____

□ **NONE (I do not have any of the conditions or symptoms included on the list provided to me today)**

I have completed this form as accurately as possible. I understand that providing incorrect information or omitting information can be dangerous to my child's health and it is my responsibility to inform the office of any changes in his/her/their health status.

Signature: _____ **Date:** _____

FINANCIAL POLICY

The following information is regarding your account at Ideal EyeCare. If you have questions or concerns about any of the information contained below, please discuss them with our staff. We look forward to providing you and your family with excellent care for all of your eye care needs.

- Payment is due at the time services are rendered. This may include co-pays, deductibles, co-insurance, non-covered services, etc. For your convenience, we accept all major credit cards as well as debit cards, cash, and checks.
- It is your responsibility to know your insurance coverage and to provide our office with the most current and accurate information. While our staff is extremely knowledgeable about many insurance plans, we are not aware of every plan since they constantly change. We cannot be held liable for misquoted benefits or eligibility.
- The determination of your best corrected vision is called a ***refraction*****.** This is considered a **non-covered service/procedure** by most insurance companies. You will be responsible for the **$55.00** fee when this service is performed. We will bill this service to your insurance as a courtesy, and if they pay any portion, you will be refunded their payment amount.
- For those patients being followed for strabismus, a sensorimotor examination will be performed at each visit. This service is separate from the office visit and may be considered a diagnostic test by your insurance, resulting in additional out-of- pocket cost to you.
- If your insurance requires a referral, you are responsible for contacting your primary care physician/pediatrician to obtain said referral. It is also your responsibility to verify that valid referrals are on file for any follow up care.
- All "self pay" patients are required to pay in full at the time services are rendered. We will extend a 20% prompt-pay cash discount on all professional services and provide you with an itemized receipt.
- Our office does **not** accept insurance liens, workers compensation, or attorney liens. Payment is the patient's responsibility and due in full at the time of service.
- All returned checks are subject to a $35.00 processing fee and will result in refusal to accept future payments by check.
- If the parents are divorced, the parent bringing the child for treatment is ultimately responsible for payment, regardless of the terms of any divorce decree or custody arrangement.
- All outstanding balances must be paid in full before scheduling surgery, except in emergent cases.
- All delinquent accounts may be sent to a collection agency and you may be charged any/all applicable collection and attorney fees. Once an account has been transferred to collections, you ***and*** your immediate family members will be **discharged** from the practice.
- Any account credit balance less than $2.00 will not be issued a refund check.
- We charge a $25.00 per page fee for any and all forms that require the doctor's signature and review. This service will not be billed to your account or your insurance company. Payment is due before the form(s) will be released. A receipt will be provided at the time of payment.
- A **$50.00** fee will be charged for all **NO SHOW** or missed appointments that are not cancelled within 24 hours of your scheduled appointment. This amount will be required before your next scheduled appointment. As a courtesy to all patients, we will try to notify you with a reminder call 48 hours prior to your visit. It is very important that you keep our office updated with your most current information.

I understand that even if Ideal EyeCare is contracted with my health care plan, I am ultimately responsible for payment of both covered and non-covered services performed during the course of my treatment. I request payment of authorized benefits by my insurance plan be made on my behalf to Ideal EyeCare for services rendered and request that Ideal EyeCare submit claims for payment for those services on my behalf to my insurance carrier. I authorize release of medical information to the insurance carrier or its agents to allow for benefit or claim determination.

_____ _____

Patient Signature/Legal Guardian Signature **Date**

_____ _____

Please Print Patient's Name **Date**