GALLOWAY
Eye Care Professionals, Inc
5688-A West Broad Street
Galloway, OH 43119
Phone: 614-853-2020 Fax: 614-853-0154
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Name: _____Date: _____/_____/_____
Age: _____Date of Birth:____/___/_____Gender: M / F Social security #: _____
Address: _____City: _____State: ____ Zip Code: _____
Home Phone: (___)___-____Cell Phone:(___)_____-_____ Parent Work Phone: (____)_____

Account Responsible information

Guardian: _____ Salutation: Mr. Mrs. Miss Ms. Dr. Prof.
Guardian Social Security #: _____ Email address: _____

***Children(under 18) cannot be their own account responsible (financial and responsible for making medical decisions). We must have the name, SS#, and contact information for at least one parent or guardian or your child will not be seen.**

Vision insurance carrier: VSP EyeMed Medicaid/Caresource/Molina Other: _____
Medical insurance carrier: Anthem Aetna Cigna Medical Mutual Medicare
Tricare Humana United HealthCare Medicaid/Caresource/Molina Other: _____

Primary insured name: _____ DOB: _____
Secondary insurance name:_____ Ins ID#_____ DOB: _____
**Please have your insurance cards ready for our staff to copy, thank you. Co-pays are due at the time of service.

Reason for Examination (circle all that apply): blurred vision at distance / near / computer

eyes watery/itchy eyes dry headaches eyestrain eye pain redness flashes/floaters

need new contact lenses / glasses referred by another doctor vision therapy assessment

reading problems double vision failed screening exam at school/doctor's office

Ocular History:

Last Eye Exam (month/year):_____Doctor's name: _____
Did your child have a vision screening this year? Y / N If yes, did they pass? Y / N
Does your child currently wear glasses? Y / N Is your child interested in contact lenses? Y / N

***Contact lens services are not covered under a regular eye exam.** In order to obtain a prescription for contact lenses, an additional evaluation (contact lens fitting) must be done. The price for this service varies based on your prescription and the complexity of the fit. Your fitting fee will cover any necessary follow up visits and any diagnostic lenses used to determine your contact lens prescription. Our doctors are committed to your success in contact lenses. If you have questions regarding this fee, please talk to a staff member.

Personal Ocular History (has your child ever been diagnosed with or complain of the following)**:**

Injury	Y / N
Retinal Disease	Y / N
Blindness	Y / N
Strabismus (Eye turn)	Y / N
Amblyopia (Lazy Eye)	Y / N
Dryness	Y / N
Flashes	Y / N
Floaters	Y / N
Vision Loss	Y / N

Other (please describe): _____

Does your child play contact sports (football, soccer, basketball, etc?) Y / N
Sports related injuries within the last year:
_____

_____

Family Ocular History (has a blood relative been diagnosed with the following):

Glaucoma	Y / N	Relationship: _____
Cataracts	Y / N	Relationship: _____
Macular Degeneration	Y / N	Relationship: _____
Retinal Disease	Y / N	Relationship: _____
Blindness	Y / N	Relationship: _____
Strabismus (eye turn)	Y / N	Relationship: _____
Amblyopia (lazy eye)	Y / N	Relationship: _____
Other (please describe)	Y / N	Relationship: _____

_____

Medical History:

Pediatrician/Family Doctor:_____ Last Exam (month/year):_____
Reason for last exam: check up disease management acute illness annual physical
Are immunizations current: Y / N If no, list why: _____

This child is your natural child foster child adopted child Other: _____

Birth history (if known):

Was the pregnancy uneventful? Y / N List complications: _____
Was the delivery full term? Y / N If no, list length of pregnancy here: _____
Was the delivery uneventful? Y/ N List complications: _____
Birth weight (if known) _____ APGAR score (if known): _____

Personal medical history (does your child currently have or take medication for the following):

General Health:

Recent trauma	Y / N
Weight loss/gain	Y / N
High fever	Y / N
Other: _____	

Cardiovascular:

Congenital heart defect	Y / N
Other: _____	

Ears, nose, mouth, throat:

Chronic sinusitis	Y / N
Chronic strep	Y / N
Hearing loss	Y / N
Other: _____	

Respiratory:

Asthma	Y / N
Other: _____	

Gastrointestinal (GI):

Reflux	Y / N
Hernia	Y / N
Other: _____	

Musculoskeletal:

JRA	Y / N
Muscle pain	Y / N
Cerebral palsy	Y / N
Other: _____	

Integumentary (skin):

Rosecea	Y / N
Eczema	Y / N
Psoriasis	Y / N
Other: _____	

Neurological:

Seizures	Y / N
Migraine	Y / N
Concussion	Y / N
Other: _____	

Psychiatric:

Depression	Y / N
Anxiety	Y / N
AD/HD	Y / N
Other: _____	

Endocrine:

Diabetes	Y / N
Thyroid	Y / N
Pituitary disorders	Y / N
Other: _____	

Blood/ Lymphatic:

Anemia	Y / N
Sickle Cell	Y / N
Leukemia	Y / N
Other: _____	

Genitourinary:

Recurrent bladder inf	Y / N
Kidney disorders	Y / N
Other: _____	

Allergic/Immunologic:

Seasonal allergies	Y / N
Immunodeficiency	Y / N
HIV/ AIDS	Y / N
Other: _____	

Medications:_____
_____

Does your child have any known drug allergies: Y / N List: _____
Are there members of your household that smoke? Y / N
If yes, how many parents smoke in the home? One / both
If there are no smokers in the household, please initial here _____

Family Medical History (has a blood relative been diagnosed with the following):

High blood pressure	Y / N	Relation: _____	Diabetes	Y / N	Relation: _____
Heart attack	Y / N	Relation: _____	Thyroid problems	Y / N	Relation: _____
Stroke	Y / N	Relation: _____	Multiple Sclerosis	Y / N	Relation: _____
Cancer	Y / N	Relation: _____	Lupus	Y / N	Relation: _____

Social history:

Grade level: _____ School: _____

Has your child been evaluated for or is currently on an IEP or 504 plan? Y / N

If yes, list subjects included on that plan: _____

If yes, list accommodations your child is receiving: _____

_____

Reading level for age: Above average average below average significantly below average

Math level for age: Above average average below average significantly below average

Has your child been held back a grade? Y/N If yes, what grade: _____

Additional educational concerns (teacher or parent): _____

_____

Does your child have any developmental delays? Y / N Please list: _____

_____

Is your child receiving any special interventions (such as speech, occupational, or physical therapy, tutoring, etc)? Y / N If yes, please list here:_____

Sports/hobbies not previously listed: _____

Special visual needs: _____

Please list **any** surgeries your child has had: _____

Other pertinent health history: _____

_____

**Thank you, your information is protected under HIPAA and is confidential.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Galloway Eye Care Professionals, Inc. Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____

By signing above, I acknowledge the following:

1. I authorize Galloway Eye Care Professionals, Inc. to bill my vision and/or medical insurance (if a medical diagnosis exists) for services rendered. I understand that I may be responsible for services not covered by my insurance company. I authorize the release of information necessary to process my claims.
2. I understand that all co-payments and payments for services not covered by insurance are due at the time of service.
3. I understand that professional fees are **not refundable**.
4. My health information will not be released to any person or entity without my written consent, as this is protected information. In the case of children, health information will only be released to a parent or guardian present at the time of the examination unless other instructions have been given to the staff/doctors of Galloway Eye Care Professionals, Inc.
5. It is also acknowledged that any unpaid balances may be subject to collections and is the responsibility of the guarantor.

The following individuals have my authorization to access my Protected Information:

Name:_____ **Relationship:**_____ **Date of Birth:**_____

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