Welcome to University Children's Eye Center

We are pleased that you have chosen us as your pediatric eye specialists. We will do everything we can to make each visit as pleasant as possible.

What to Expect at Your Child's First Visit to Our Office

During an ophthalmic exam, the doctor will evaluate your child's visual acuity, eye movement, eye alignment, and overall health of the eye. Your child will also be screened and evaluated for amblyopia ("lazy eye"), strabismus (misaligned or "crossed" eyes), cataracts, glaucoma, retinal abnormalities, as well as other ocular and general medical conditions which might affect eyesight.

We try to make the exam fun for your child. During much of the exam, younger children will be looking at age-appropriate toys. Games are played to obtain the cooperation of young children. A comprehensive eye examination takes time, so plan to spend <u>at least</u> one and a half hours in our office.

For most initial eye examinations, your child's eyes will be dilated with eye drops. This allows the ophthalmologist or optometrist to examine vital structures of your child's eyes including the optic nerve and retina. Dilation will make the pupils look larger than normal. Some children may have difficulty reading and be light sensitive for up to 24 hours, but the major effect of the drops is gone in approximately 6 to 8 hours. On a bright day, your child may be sensitive to sunlight, so you may wish to bring sunglasses if your child has them and/or limit the time spent outside. You may need to help your school-age child with homework and other near work as the eyesight may still be blurry for several hours.

What to Bring with You to Your Child's Appointment

- ❑ The completed 4 pages of registration forms. (Please do not mail these in.)
- ❑ Any glasses or contact lenses that your child wears.
- ❑ If your child has seen other eye doctors for an ongoing problem, it can be helpful to have a copy of the records. It is usually best for you to call and request that the records be sent to you directly. Bring them with you the appointment.
- ❑ Your insurance card, co-payment, and referral or authorization number (if required), if you plan on using insurance with which we participate.

As a courtesy to our other patients, please call us to reschedule your appointment if your child has a cold, fever, chicken pox, or other contagious disease. If you must cancel your appointment for any other reason, please give us at least 48 hours notice so that we can accommodate patients who have been waiting for their appointments.

We look forward to seeing you in our office. If you have any questions, do not hesitate to call.

The Doctors and Staff of University Children's Eye Center

Main Office
4 Cornwall Court
East Brunswick, NJ 08816
phone 732/613-9191
fax 732/613-1139

Bridgewater Office
678 Route 202/206 North Bldg 5
Bridgewater, NJ 08807
phone 908/203-9009
fax 908/203-9010

University Children's Eye Center, P.C.

REGISTRATION

Main Office	Bridgewater Office
4 Cornwall Court	678 Route 202/206 North Bldg 5
East Brunswick, NJ 08816	Bridgewater, NJ 08807
732/613-9191	908/203-9009

Name of Patient (Last, First, MI) ______________________ Date of Birth __________

Address ______________________ City ______________ State _____ ZIP Code ______

Home Phone ( ) __________ Alternate Phone ( ) ext. __________ Sex ☐ Male ☐ Female

Primary Doctor's Name ______________________ Address ______________________

Other Physician(s) from whom the patient receives care (Please give name, specialty, address, and phone for each):

Were you referred to us by your pediatrician? ☐ Yes ☐ No

If "no", who referred you, or how did you hear of us?

We would like to send a report of your eye exam(s) to all physicians who care for you or your child. Please indicate here if you prefer that we NOT send a report to any of the above physicians:

Person Responsible for Account

Name ______________________ Address (if different from patient's) ______________________

Relation ______________________ City ______________ State _______ ZIP Code ______

Work phone number ( ) ext. __________ Social Security Number ______________________

The Parent or Guardian who accompanies a pediatric patient is responsible for payment at the time of service and for the child's account, unless prior arrangements have been approved.

PRIMARY INSURANCE – Please give complete information on all plans in which the patient is enrolled.

Insurance Subscriber (Last name, First, Middle Initial) ______________________

Relationship to patient Please select. Date of Birth __________ Social Security Number __________

Address (if different than patient's) ______________________ Home Phone ( )

City ______________________ State ________ ZIP Code ________

Subscriber employed by ______________________ Business phone ( ) ext.

Insurance company ______________ Subscriber # ______________ Group/Contract # __________

ADDITIOINAL INSURANCE – If patient is enrolled in more than one health plan, please complete the following.

Insurance Subscriber (Last name, First, Middle Initial) ______________________

Relationship to patient Please select. Date of Birth __________ Social Security Number __________

Address (if different than patient's) ______________________ Home Phone ( )

City ______________________ State ________ ZIP Code ________

Subscriber employed by ______________________ Business phone ( ) ext.

Insurance company Subscriber # Group/Contract #

This Section for Pediatric Patients Only:

Who is accompanying the child today?	Mother's Information
Name ______________	Full Name ______________
Relation ______________	Daytime Phone ( ) ext.
Do you have legal custody of the child? ☐ Yes ☐ No	Does the mother have legal custody of the child? ☐ Yes ☐ No
	Father's Information
	Full Name ______________
	Daytime Phone ( ) ext.
Written consent for us to treat the child is required if not.	Does the father have legal custody of the child? ☐ Yes ☐ No

I certify the above information is correct to the best of my knowledge. I understand that I am financially responsible for this **patient's account. I understand and accept that payment is due at the time of service unless we accept insurance assignment** for a covered service. I also acknowledge that a cancellation fee of $25 will be charged if this office is not notified 48 hours prior to the cancellation of an appointment, except in the case of an emergency.

Signature of Responsible Party:______________________ Date:__________

Signature must be an original INK signature

University Children's Eye Center, P.C.

New Patient Questionnaire: Medical and Family History

Name of Patient ______________________ Date of Birth __________

Why is the patient here to see the doctor? ______________________

History of Eye Problems: Has the patient had any of the following?

Yes	No		Age	Yes	No		Age
☐	☐	Eye exam	______	☐	☐	Eye injury	______
☐	☐	Glasses	______	☐	☐	Eye surgery	______
☐	☐	Patching	______	☐	☐	Other eye problems:	______

Recent Ocular Symptoms

Yes	No		How long?	Yes	No		How long?
☐	☐	Frequent tearing or discharge	______	☐	☐	Frequent headaches	______
☐	☐	Crossed or wandering eye	______	☐	☐	Light sensitivity	______
☐	☐	Double vision	______	☐	☐	Tired eyes when reading	______
☐	☐	Abnormal head or eye position	______	☐	☐	Clumsiness or bumping into things	______
☐	☐	Abnormal eye movements	______	☐	☐	Can't make normal eye contact	______
☐	☐	Excessive squinting	______	☐	☐	Blurred vision	______
☐	☐	Excessive eye rubbing	______	☐	☐	Other symptoms	______
☐	☐	Change in school or work performance	______			______	

Review of Symptoms (Medical History):

Does the patient currently have or have a history of any of the following? Give details on "yes" responses.

Yes	No		
☐	☐	Fever or weight loss	______
☐	☐	Birthmarks, rash, or skin lesions	______
☐	☐	Frequent ear infections	______
☐	☐	Other ear, nose and throat problems	______
☐	☐	Developmental delays	______
☐	☐	Behavioral or attention deficits	______
☐	☐	Heart murmurs or other problems	______
☐	☐	Asthma or respiratory problems	______
☐	☐	Arthritis or joint problems	______
☐	☐	Kidney or urinary disease	______
☐	☐	Diabetes	______
☐	☐	Digestion or gastrointestinal disorders	______
☐	☐	Sickle cell trait or disease	______
☐	☐	Genetic syndrome	______
☐	☐	Seizures or neurological problems	______

Allergies – Does the patient have any allergies

To medications? ☐ Yes ☐ No Please list: ______________________

To substances? ☐ Yes ☐ No Please list: ______________________

University Children's Eye Center, P.C.

New Patient Questionnaire: Medical and Family History

Has the patient ever had surgery? ☐ Yes ☐ No If yes, please give details and dates below

____

____

List any medications the patient is taking, including eye drops:

____

____

Birth History (Pediatric Patients only):

Birth weight: __________ lb. __________ oz.

Yes	No		Yes	No	
☐	☐	Problems during pregnancy	☐	☐	Delivered more than 2 weeks early or late
☐	☐	Problems during delivery or forceps delivery	☐	☐	Baby kept in hospital due to illness
☐	☐	Delivery by cesarian section	☐	☐	Delayed development

Family History: Have any of the patient's *relatives* had any of the following? Please indicate the relation to patient.

Yes	No			Yes	No		
☐	☐	Glasses before the age 6	________	☐	☐	Cataracts in childhood	________
☐	☐	Amblyopia ("lazy eye")	________	☐	☐	Glaucoma in childhood	________
☐	☐	Patching treatment	________	☐	☐	Other serious eye disease	________
☐	☐	Strabismus ("crossed eye")	________	☐	☐	Complications from anesthesia	________
☐	☐	Eye muscle surgery	________	☐	☐	Blindness	________
☐	☐	Genetic disease (that runs in the family)	________	☐	☐	Other serious illness:	________

Are both parents alive and in good health? ☐ Yes ☐ No

Other medical concerns or problems not listed earlier:

____

____

Thank you.

I understand that the information that I have given is correct and complete to the best of my knowledge, and that it is my responsibility to inform this **office of any changes in my or my child's medical status. I** authorize staff of University Children's Eye Center, P.C. to perform the necessary in-office examinations that my child (or myself in an adult patient) may need.

____

Signature of patient or guardian Date

I verbally reviewed the medical information above with the parent/guardian and/or patient named herein.

____

Doctor's Signature Date

Doctor's Comments: