PATIENT HISTORY (Pediatric Established Patients)

Last Name_____First Name_____ Age ____ M/F Occupation_____

Who may we thank for referring you to our office? _____How did you hear about us?_____

Primary Physician_____Physician Phone#_____ Fax#_____

Last Physical Exam _____
Headaches frequent/rarely/never Any recent changes in headaches? Y/N Explain_____
Diabetes Y/N Type ____Date of Diagnosis _____ Last Fasting Glucose_____ Last A1C____ Last Triglyceride ____
Hypertension Y/N Last Blood Pressure _____
Allergies Y/N To What?_____ What happens?_____
Medication Allergy Y/N To What?_____What happens?_____
Cigarettes/Tobacco: Smoker: Every Day/Some Days Former Smoker Never Smoked
Alcohol frequent/occasional/never Other substance(s) _____

PERSONAL EYE INFORMATION

Do you wear glasses? Y/N Distance/Reading/Both Blur at distance or near without glasses? Y/N
Blur while wearing glasses for distance? Y/N Blur while wearing glasses for reading? Y/N
Contact Lenses Y/N Type _____ Blurry Vision with contact lenses Y/N
Are your contact lenses comfortable? Y/N Normal wearing time _____ Solution Type _____
Contact Lens Replacement Schedule daily/2 weeks/monthly/ quarterly/ yearly/other_____
Have you had an eye operation since last eye exam? Y/N Type _____ Date _____
Have you had an eye injury since last eye exam? Y/N Type_____ Date _____
Glaucoma Y/N Cataracts Y/N Do you ever see double? Y/N Eye pain/Eyestrain Y/N

Please complete the following only if there are any changes since the last eye exam.

MEDICAL INFORMATION

Gastrointestinal	Y/N	Nervous	Y/N	Eyes	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Mental	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Endocrine	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Blood/lymph	Y/N
Allergic/immunologic	Y/N	Other	Y/N	HIV	Y/N

Please explain _____

Updated medications/surgeries_____

FAMILY HISTORY

Glaucoma Y/N Relation _____ Macular Degeneration Y/N Relation _____
Cataracts Y/N Relation_____ Retinal Detachment Y/N Relation _____
Diabetes Y/N Relation_____ High Blood Pressure Y/N Relation _____
Other Eye Condition(s) Y/N Type _____ Relation _____

Please initial if there are no changes to my medical/surgical history/medications/family history _____

Additional Information _____

Signature _____Date _____

Children's Vision Questionnaire

Name_____ Age_____ Date _____

Pediatrician _____

Pediatrician Address & Phone# _____ Fax#_____

BINOCULAR
VISION & VISUAL EFFICIENCY HISTORY
(Please circle Y or N)

Complains of blurred vision	Y or N	Holds things very close	Y or N
Complains of blurred vision		Loses place often	Y or N
when looking near to far or far to near	Y or N	Complains of eyestrain	Y or N
Complains of headaches	Y or N	Must use finger to guide and keep place	Y or N
Rubs eyes	Y or N	Skips lines and words often	Y or N
Inattentive	Y or N	Misreads parts of words	Y or N
Avoids reading	Y or N	Covers or closes one eye when reading	Y or N
Poor reading comprehension	Y or N	Complains of double vision	Y or N
Is tired after reading	Y or N	Complains of words moving on the page	Y or N
Slow worker	Y or N	Complains of words running together	Y or N
All above negative	Y or N		

GENERAL BEHAVIOR		**SIGNS OF VISUAL PROCESSING DISORDERS**	
High activity level	Y or N	Reverses letters and numbers	Y or N
Poor attention span	Y or N	Mistakes words with similar beginnings	Y or N
Impulsivity	Y or N	Can't recognize same word	
Frustrates easily	Y or N	repeated on the page	Y or N
Doesn't listen when spoken to	Y or N	Poor recall of visually presented materials	Y or N
Poor memory	Y or N	Trouble with spelling	Y or N
More active than other		Sloppy writing skills	Y or N
children his(her) age	Y or N	Erases Excessively	Y or N
All above negative	Y or N	All above negative	Y or N

Does your child like school? Y or N
How are his(her) grades? Excellent, Good, Fair, Poor
Please list any academic area(s) of difficulty _____
Do you feel your child is achieving up to potential? Y or N

Freehold Eye & Vision Care LLC
Dr. Carolyn LoBocchiaro, OD
FINANCIAL RESPONSIBILITY

Healthy eyes are necessary for good vision. As part of her thorough comprehensive eye exam, Dr. LoBocchiaro concentrates on evaluating eye health. Please be advised, if ocular medical conditions are diagnosed or if there are medical concerns which need to be addressed during the "routine" exam, the patient will be responsible for their medical co-payment and/or deductible even if they are using a vision plan.

A visual field screening and ocular photography are essential components for a complete ocular health assessment.

VISUAL FIELD tests your peripheral vision and neurologic health. It is extremely important for detecting underlying causes for headaches, even if they are only occasional, detecting early glaucoma and monitoring peripheral vision for patients who drive.

OCULAR PHOTOGRAPHY is important for baseline testing and monitoring of the internal and external eye health. It is especially important in aiding the diagnosis of early glaucoma and managing diabetes, hypertension, macula irregularities and ocular freckles. Detecting and monitoring for changes in the future is much more accurate when a photo is available as a baseline for comparison.

For your convenience, Freehold Eye & Vision Care will bill your medical insurance company for these tests even if you are using your vision insurance for your exam. These tests are normally covered in full but on occasion, a co-payment is required, especially if you haven't met your deductible. If that is the case, we will bill you after your insurance claim is processed.

REFRACTION (determination of a spectacle lens prescriptions) Most medical insurance companies do not cover this part of your examination, if this information has been determined prior to your visit, **you will be responsible for the Refraction fee of $60.00 at the time of the visit as well as any insurance specialist copayment**.

CONTACT LENS FITTING (this is a separate service) This is not part of a comprehensive eye exam. Extra testing is involved to properly fit contact lenses and monitor your corneal health even if you are an established contact lens wearer. Additional fees also apply even if you have a vision plan. Payment of this fee is expected on the date of service. **Contact lens fitting fees range from $135 to $260 depending on the complexity of the fit and if instruction is required. Rigid contact lens fittings are $260.**

PRESCRIPTIONS I consent to having my contact lens/eyeglass prescription released electronically if necessary.

NO-SHOW POLICY Failure to cancel with 24 hours advanced notice will be labeled a "no-show" in your chart. An administrative fee of $25.00 MAY be billed to your account for this missed appointment. Three (3) "no-shows" within one calendar year MAY result in a temporary suspension of services or dismissal from the practice. Certainly, we understand that last minute emergencies may arise in your schedule and simply request you notify us as soon as you are aware there is a conflict. No-Show charges are the patient's responsibility and cannot be billed to your insurance company.

TELEHEALTH SERVICES are offered for your convenience. Billing standards apply. Patient will be responsible for all applicable co-payments and/or deductibles.

I certify that I and/or my dependent(s) have insurance coverage that has been provided directly to Dr. Carolyn LoBocchiaro for all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I am responsible for providing the office with a referral if necessary. I authorize the use of my signature on all insurance submissions. I acknowledge responsibility for accruing interest as well as the fees associated with the collections of my account should it become delinquent. The above-named physician may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.
I am aware that if the charges are not paid at the time of service, I am subject to a $15.00 late fee. I am aware that there is a $20.00 bounced check fee.

Name of Patient _____ Date_____

Signature of Patient/Legal Guardian _____

Patient Contact Authorization

Freehold Eye & Vision Care, LLC
555 Iron Bridge Road
Suite #16
Freehold, NJ 07728

I, _____, authorize and give permission to Freehold Eye & Vision Care, or any practice staff members, to leave messages regarding my medical information status and/or treatment on the following telephone (s).

Home: _____

Cell: _____

I authorize and give permission to Freehold Eye & Vision Care, or any practice staff members, to communicate with the following physicians regarding my medical status and/or treatment:

Name: _____ Specialty: _____

Name: _____Specialty: _____

I authorize and give permission to Freehold Eye & Vision Care, or any practice staff members, to communicate with the following people regarding my medical status and/or treatment:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient/Parent Guardian Name: _____

Signature: _____ Date: _____

Freehold Eye & Vision Care, LLC
555 Iron Bridge Road, Suite 16
Freehold, NJ 07728
Carolyn LoBocchiaro, O.D.
Optometric Physician

Dilated Fundus Exam

This important diagnostic procedure involves instilling medication into the eyes to dilate (open up) the pupil. This allows the health of the entire retina (the tissue located behind the eye) to be assessed. In the non-dilated state, only the central portion of the retina and the optic nerve can be seen. Viewing the entire retina is important in detecting certain diseases that may only show up in areas not usually seen during a regular evaluation.

This test is strongly recommended for the following:

- any patient with moderate or high nearsightedness (>3 units of myopia)
- any patient with systemic diseases especially diabetes or hypertension
- any patient with complaints of flashes or floaters
- all first- time patients in order to establish a baseline

The side effects of the drops are blurry vision at near, sometimes far, and an increased sensitivity to light. The medication takes 4-6 hours to wear off completely but starts to wear off after 2 hours.

I understand the importance of the dilation but I am **NOT** interested in having it today. If I decide to return for this test, I will be responsible for any fees associated with an additional office visit.

Name of Patient or Legal Guardian: _____

Signature of Patient or Legal Guardian:_____

Date: _____