

# KRAMER FAMILY VISION INFORMATION FORM (FOR PTS ↓18)

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
First Name MI Last Name

Address \_\_\_\_\_ SS# \_\_\_\_\_  
Street City State Zip

Phone:  Home \_\_\_\_\_  Cell/Work#1 \_\_\_\_\_ Contact Name \_\_\_\_\_  
 Cell/Work#2 \_\_\_\_\_ Contact Name \_\_\_\_\_

(Please provide all possible contact numbers and check preferred method of contact for eyeglass and/or contact lens orders)

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

## HEALTH HISTORY

Average daily computer use: \_\_\_\_\_ hours

Date of last eye exam \_\_\_\_\_ Doctor/Place \_\_\_\_\_

Has he/she ever worn glasses?  Yes  No Contact Lenses?  Yes  No Type: \_\_\_\_\_

HAS **THE CHILD** EVER BEEN TREATED OR DIAGNOSED WITH ANY OF THE FOLLOWING?

- |                                      |   |   |
|--------------------------------------|---|---|
| <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Blindness              |
| <input type="checkbox"/> Glaucoma    | <input type="checkbox"/> Eye Injury           | <input type="checkbox"/> Strabismus/Crossed Eye |
| <input type="checkbox"/> Cataracts   | <input type="checkbox"/> Retinal Problems     | <input type="checkbox"/> Amblyopia/Lazy Eye     |

DOES **THE CHILD** EXPERIENCE ANY OF THE FOLLOWING?

- |   |                                  |   |   |
|---|----------------------------------|---|---|
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Burning | <input type="checkbox"/> Flashes of Light | <input type="checkbox"/> Light Sensitivity    |
| <input type="checkbox"/> Double Vision  | <input type="checkbox"/> Itching | <input type="checkbox"/> Floaters         | <input type="checkbox"/> Redness              |
| <input type="checkbox"/> Dry Eye        | <input type="checkbox"/> Tearing | <input type="checkbox"/> Eye Pain         | <input type="checkbox"/> Unexplained Headache |

IS THERE A **FAMILY** HISTORY OF THE FOLLOWING? (please indicate relation next to condition: M, F, GM, GF, B, S)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Glaucoma _____        | <input type="checkbox"/> Retinal Problems _____     | <input type="checkbox"/> Diabetes _____      |
| <input type="checkbox"/> Early Cataracts _____ | <input type="checkbox"/> Macular Degeneration _____ | <input type="checkbox"/> Cancer _____        |
| <input type="checkbox"/> Blindness _____       | <input type="checkbox"/> Crossed Eye/Lazy Eye _____ | <input type="checkbox"/> Heart Disease _____ |

Date of last routine health appt \_\_\_\_\_ Name of Regular Physician \_\_\_\_\_

HAS **THE CHILD** EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Currently Ill            | <input type="checkbox"/> Gastrointestinal Problems | <input type="checkbox"/> Thyroid Problem _____    |
| <input type="checkbox"/> Cardiovascular Problems  | <input type="checkbox"/> Hepatitis                 | <input type="checkbox"/> Sickle Cell/Anemia       |
| <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Kidney Problems           | <input type="checkbox"/> Blood Clot/Bleeding      |
| <input type="checkbox"/> Heart Surgery            | <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> HIV/AIDS                 |
| <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Muscle Pain or Disorders  | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Pace Maker               | <input type="checkbox"/> Skin Disorders            | <input type="checkbox"/> Cancer (type/when) _____ |
| <input type="checkbox"/> High Cholesterol         | <input type="checkbox"/> Stroke/Neurological       | <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> Ear/Nose/Throat Problems | <input type="checkbox"/> Anxiety/Depression        | <input type="checkbox"/> Currently Pregnant       |
| <input type="checkbox"/> Respiratory Problems     | <input type="checkbox"/> Diabetes                  | How far along? _____                              |

DO THE CHILD USE TOBACCO PRODUCTS, ALCOHOL, OR ANY OTHER SUBSTANCES?  Yes  No Describe: \_\_\_\_\_

IS THE CHILD CURRENTLY ENROLLED IN:  Auditory/Occupational/Physical Therapy  Resource/Speech/Tutoring

DOES THE CHILD USE ANY EYEDROPS? (include over the counter) \_\_\_\_\_

PREFERRED PHARMACY \_\_\_\_\_

LIST ALL MEDICATIONS/SUPPLEMENTS (or provide a medication list to the receptionist): \_\_\_\_\_  
\_\_\_\_\_

LIST ALL ALLERGIES: (include allergies to MEDICINE or ENVIRONMENTAL SUBSTANCES)

HOW DID YOU HEAR ABOUT US?

- Phonebook  Newspaper  Internet  Friend/Family \_\_\_\_\_  Other \_\_\_\_\_

**PLEASE CONTINUE ON THE BACK SIDE**

**Insurance Information:** All charges not covered by the insurance carrier will be the responsibility of the patient.

Vision insurance will cover routine services and glasses--benefits only covered once per year (or every 2 years).

Medical insurance MAY cover the examination if there is a medical problem with the eyes.

**Vision Insurance:** Company \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_\_\_

Policy Holder's Social Security # \_\_\_\_\_ \*\*This is only necessary if you do not have a card

**Medical Insurance:**

Primary Insurance Company \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_\_\_

**I attest that the information included on this form is correct to the best of my knowledge**

**I understand the HIPAA Privacy Policy as stated below and I understand that a copy of the full privacy practices of Kramer Family Vision may be furnished upon request.**

**Legal Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Summary of HIPAA NOTICE OF PRIVACY PRACTICES

**WE MAY USE YOUR INFORMATION FOR TREATMENT PURPOSES BY:**

- Setting up an appointment or confirmation of an appointment already made (including reminder postcards and messages left on an answering machine).
- Testing or examining your eyes; Prescribing glasses, contact lenses, or eye medications (and faxing them to be filled) ; showing you vision therapy or low vision aids .
- Referring you to another doctor or clinic for eye care, surgery, low vision aids, or vision therapy services or getting copies of your health information from another professional.

**WE MAY USE YOUR INFORMATION FOR PAYMENT PURPOSES BY:**

- Asking about health and vision care plans or other sources of payment.
- Preparing and sending bills or claims.
- Collecting unpaid amounts (ourselves or through a collection agency or attorney).

**WE MAY USE YOUR INFORMATION TO MAINTAIN THE HEALTH CARE OPERATIONS OF OUR OFFICE BY:**

- Financial or billing audits, Internal quality assurance, Personnel decisions, Participation in managed care plans, Defense of legal matters, Business planning, or Outside storage of records

\*We routinely use your health information inside our office for these purposes without any special permission.

\*If we need to disclose your health information outside our office for these reasons, we will ask you for special written permission.

**USES/DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION:**

We are obligated to release your information in the following circumstances:

- When mandated by state or federal law that certain health information be reported.
- Disclosures to governmental authorities regarding victims of suspected abuse, neglect, or domestic violence.
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime.
- Unless you object, we will also share relevant information about your eye care with your family or friends who are helping you with your eye care.