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INFANT'S QUESTIONNAIRE

Infant's Name: _____ Nickname: _____
Address: _____
Town: _____ State: _____ Zip Code: _____
Home telephone: _____ Date of Birth: _____
Referred by: _____

Father's Name: _____ Occupation: _____
Date of Birth: _____ Cell Phone: _____
Work Phone: _____ Email Address: _____

Mother's Name: _____ Occupation: _____
Date of Birth: _____ Cell Phone: _____
Work Phone: _____ Email Address: _____

Parents, may we add you on Facebook?___ If yes, what is your contact name?_____

Brothers and Sisters	Birthdate	Age	Grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRESENT SITUATION

1. Is your baby having any visual difficulties? If so, what kind of difficulties? _____
_____
2. Have you ever seen your infant's eyes turn in or out? _____
   If yes, when? _____
3. Have you ever been told your infant has a lazy eye? _____
   If yes, by whom? _____
4. Does anyone in your family have a lazy eye or a turned eye? _____

5. How long has the difficulty been noted? _____
6. Does your infant rub his/her eyes? _____
7. Are the eyes frequently red? _____
8. Was or is your infant breast or bottle fed? _____

DEVELOPMENTAL HISTORY

1. Term of pregnancy: _____ Normal birth? _____ Were there any complications before, during or immediately following delivery? _____

_____

2. Did you experience any illnesses or injuries while pregnant? _____
3. What medications did you take while pregnant? _____
4. Was anesthetic used during the birth? _____ APGAR score: _____ Infant's birth weight: _____
5. Was there any unusual position of your infant's head, face, body or cord at birth? _____

_____

6. Did your baby crawl? _____ on all fours? _____ at what age? _____
7. At what age did your infant sit alone? _____ walk alone? _____
8. Speech: Age when first word spoken_____ sentences? _____
9. Is your infant active? _____
10. What circumstances make your infant irritable? _____
11. What comforts your infant? _____

GENERAL HEALTH

1. Please list past illnesses including any history of high fevers or significant injuries and the age at which they occurred: _____

_____

2. Health at present is: good _____ fair _____ poor _____
3. Is your child under any medication? _____ If so, what? _____
4. Has your infant been inoculated for DPT? _____
5. Name and address of pediatrician: _____

_____

May we send a report of our findings to your infant's pediatrician? Yes _____ No _____

6. Has your infant been seen previously for a visual examination? _____ If so, by whom, when, and what was the outcome? _____
7. Give a brief description of your infant's personality: _____

_____

Parent's or guardian's signature _____ Date _____

Your signature acknowledges receipt of our Notice of Privacy Practice and also authorizes us to file insurance claims on your behalf.

FINANCIAL RESPONSIBILITY STATEMENT

To Our Patients with Insurance Benefits:

We will be happy to help you file your insurance claim forms or take assignment on your insurance benefit as designated by the _____ Plan of which you state you are a member. This service will be provided without additional charge to you. We will also do all that we can to help you receive maximum benefits.

However, in the event that the insurance plan determines that you are not eligible at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you do hereby agree to be financially responsible for any and all charges incurred by you, and not paid by your insurance plan.

RESPONSIBLE PARTY: _____

_____

Signature Date

BILLING ADDRESS: _____

Street Address/Apt. #

_____

City, State, Zip

_____

Telephone

CANCELATION POLICY

All patients will be charged $55.00 for missed appointments if 48 hours notice is not given for cancellation.
I have read this statement and agree to the above.

Patient's or parent's signature _____ Date _____

CELL PHONE POLICY

PLEASE PUT YOUR CELL PHONE ON SILENT MODE
During evaluations and vision therapy sessions, it is important that you are not distracted or your child during the appointment. During a child's evaluation, it is also important that you observe the testing and how your child responds. If for some reason there is a call you have to take, please step out of the room to do that.

Please initial _____ Date _____