



WELCOME

Thank you for choosing our office for your eyecare needs. We're glad to help if you have questions.

All Patient Information is Confidential

Name: _____ Date: _____

Address: _____ City/State: _____ Zip _____

Home Phone: _____ Cell Phone: _____ Text OK?: _____

Email: _____ Birthdate: _____

Patient's SSN: _____ Employer: _____

Primary Physician/Pediatrician: _____

Marital Status: _____ Children: _____

Height: _____ Weight: _____

Preferred Language: English Spanish Other: _____

- Race: American Indian or Alaskan Native
 Asian
 Black or African American
 Hispanic
 Native Hawaiian or Pacific Islander
 White

Preferred Pharmacy: _____ Phone: _____

Insurance Information

If you are using insurance, we need to copy your medical and vision cards. We treat both medical eye problems as well as vision care. Thank you.

Primary Member's Name: _____ Primary Member's Employer: _____

Primary's social security #: _____ Primary Member's Birthdate: _____

Please Fill Out Both Sides

Your Eye Health and Vision are important to us.

Health History

Please indicate if you or your family (blood relatives only) have any of the following:

Condition	Patient	Family	Condition	Patient	Family
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Turned Eye	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration:	<input type="checkbox"/>	<input type="checkbox"/>	Other:		

Please indicate if any of the following conditions apply to you:

- Pregnant Drug allergies Frequent Headaches
 Allergies Sinus trouble Smoker

Please list all medications your are allergic to:

- None

Medications you are currently taking:

- None

Approximate Date of Last Eye Exam? 1 year 2 years 3 or more years

Do you currently wear glasses? Yes No If yes, when do you wear your glasses?

- All the time Reading/Near work Distance tasks only work
 Work Safety Computer wear Other, please explain

Are you planning on getting new glasses today? Yes No Unsure

Have you ever worn contact lenses? Yes No

Are you renewing your contact lens prescription today? Yes No Unsure

Do you work on a computer more than 4 hours per day? Yes No

Are you interested in Laser Vision Correction? Yes No

Are you interested in Permanent Makeup with Dr. Bigheart? Yes No

How did you become aware of our practice?

- friend recommendation co-worker recommendation referred by other professional
 insurance provider other: _____

Payment Information

I authorize you to bill my insurance for any applicable services or products, and I understand that payments for non-insured services are due the same day services are rendered.

Signature _____

Welcome

NOTICE OF PRIVACY PRACTICES

METHODS OF PAYMENTS

NO INSURANCE?

No problem. Children & Family Eye Care offers a discount for all non-insurance patients for Vision or Medical exam. Accept all major credit cards, Care Credit cash, or checks.

VISION PLANS

Some vision insurance plans do not provide an insurance card. Vision Plans are usually for allowance benefits towards glasses or contact lenses. Ex: VSP, EYEMED, AVESIS, SUPERIOR VISION, etc. **MEDICAL INSURANCES DO NOT COVER THESE BENEFITS. MEDICAID (SOONERCARE) ALLOWS GLASSES ONLY FOR PATIENTS UNDER 20 YEARS OF AGE. CONTACT LENSES ARE NOT INCLUDED.**

MEDICAL INSURANCE

Refractions (checking vision) & the contact lens portion of the exam are **not covered by medical plans**. We will file your insurance on you behalf, but this does not guarantee, payment and any balance will be paid by you. If deductible has not been met for the year, you will be responsible for services rendered. We keep this information on file because we perform medical eye care. We also use medial insurances for visits with infections, foreign body, eye disease, treatments, etc...

We're glad to answer any questions regarding your insurance benefits.

Thanks!

****PLEASE SIGN HERE- PRIVACY PRACTICES****

I acknowledge that I have read or have had the opportunity to read the Notice of Privacy Practices. (Available at the front desk)

Patient Name: _____

Date: _____

Signature of Patient or Guardian: _____



Monte Harrel O.D., F.C.O.V.D. Tiffany Harrel O.D. Lynsey Bigheart O.D. Shannon Morgans O.D.
4520 S. Harvard Ste. 135 Tulsa, OK 74135 pho: 918-745-9662 fax: 918-392-7006 www.oklahomavision.com

**Please check any that apply to help us
know how to provide the best care for your child**

Developmental Checklist

- Slow reader
- Tracking issues: points with finger, omits small words while reading or copying
- Obsessed with routines or difficulty with transitions?
- Poor reading comprehension
- Homework takes longer than it should
- Hand flapping or toe walking
- Short attention span, restless, unable to stay on task
- Avoids close work
- Difficultly toilet training or issues with bed wetting
- Irregular sleep patterns
- Unreasonable fears, high anxiety, or night terrors
- Rubs eyes, squints or blinks excessively
- Double vision
- Are there any digestive/elimination problems
- Check if your child does not eat any of these food:
Milk _____ Meats _____ Vegetables _____ Fruits _____
- Smart in everything but school
- Has individual educational plan (IEP)
 - Resource room for _____
 - Tutor for _____

Continued on back

- Has repeated _____ grade
- Dietary modification in place
- Does your child take medicine for a health problem? (do not include vitamins, iron, or fluoride)
- Confuses left and right repeatedly
- Headaches after close work
- Frustration, fatigue, stress after/during close work
- Unusual posture/head tilt while reading or writing
- Difficultly with fine motor skills (eating writing holding crayon)
large motor skills (riding bike, balancing, throwing/catching ball)
- Tactile defensiveness (clothing tags, food textures)
- Speech therapy On track now? Yes No
- History of seizures
- History of ear infections
- Difficultly showing affection or shows lack of empathy
- Frequent meltdowns/tantrums
- Angry or aggressive behavior issues
- Does your child have food allergies?
- Does your child use a feeding tube or other special feeding methods?
- Does your child have a problem with:
a. Sucking b. Swallowing c. Chewing d. Gagging
- Does your child refuse to eat, throw food, or do other things that upset family dinner?