INFANT/TODDLER HISTORY FORM

Dr. Joseph Audia & Associate – 2403 West Main St Salem, WV 26426 – 345 Floral Dr.. Harrisville, WV 26362

(please us our regular history form if your child is older than 24 months)

Child's Name _____ Date of Birth _____ Today's Date _____

Parent's / Guardian's Name: _____Adoptive Parent [ ] Foster Parent [ ] Guardian [ ]

OCULAR MEDICAL HISTORY (please explain if you respond yes)

Previous Eye Exam? [ ] YES [ ] NO Date of Exam _____ Name of Last Eye Doctor_____

Glasses prescribed [ ] YES [ ] NO How are they worn [ ] FULL TIME [ ] DISTANCE ONLY [ ] NEAR ONLY [ ] NOT WORN

Has patching been prescribed [ ] YES [ ] NO Which eye [ ] RIGHT [ ] LEFT

Eye that turns or crosses [ ] YES [ ] NO Which eye [ ] RIGHT [ ] LEFT [ ] BOTH

Amblyopia or Lazy eye [ ] YES [ ] NO Which eye [ ] RIGHT [ ] LEFT

Blinks excessively [ ] YES [ ] NO Previous Eye Infection [ ] YES [ ] NO _____

Excessive tearing [ ] YES [ ] NO Previous Eye Surgery [ ] YES [ ] NO _____

Frequently rubs eyes [ ] YES [ ] NO Previous Eye Allergies [ ] YES [ ] NO _____

Previous Eye Injury [ ] YES [ ] NO _____ Other Concerns _____

PRENATAL HISTORY

Age of mother _____ Length of Pregnancy _____ Conception [ ] Normal [ ] Assisted_____

Complications [ ] Pre-eclampsia [ ] Gestational Diabetes [ ] Other Complications / Issues_____

_____

Received Prenatal Care [ ] YES [ ] NO Prenatal Vitamins Taken [ ] YES [ ] NO

Did mother have any infections during pregnancy [ ] Rubella [ ] Venereal Disease [ ] AIDS [ ] Other_____

_____ Which Trimester? _____

Was mother exposed to any Teratogens (drugs or chemicals known to cause cancer)? [ ] YES [ ] NO _____

Fetal Exposure to Drugs [ ] YES [ ] NO_____ Fetal Exposure to Alcohol [ ] YES [ ] NO_____

PERINATAL HISTORY

Type of Delivery [ ] Normal [ ] C-Section Length of Labor _____ Complications [ ] YES [ ] NO _____

Special Support Measures Required [ ] YES [ ] NO [ ] Oxygen [ ] Incubation [ ] Other _____

Apgar Scores _____ Birth Weight _____

GENERAL DEVELOPMENTAL MILESTONES (check all that apply)

[ ] Exhibits head control. [ ] Rolls over.

[ ] Able to reach and grasp objects. [ ] Orients toward sound or favorite objects (especially parents).

[ ] Crawls and creeps on hands and knees. [ ] Unusual observations or concerns _____

VISUAL DEVELOPMENTAL MILESTONES (check all that apply)

[ ] Fixates and follows parents. [ ] Makes eye contact with parents.

[ ] Responds to facial expressions. [ ] Accurately grasps for objects of interest.

GENERAL HEALTH HISTORY

Are immunizations up to date [ ] YES [ ] NO _____

Are any prescription or non-prescription medicines being taken? [ ] YES [ ] NO If yes, please list _____

_____

Who is the child's primary care physician _____ Under the care of any specialists [ ] YES [ ] NO_____

Allergies to Medications [ ] None Known [ ] Penicillin [ ] Sulfa [ ] Erythromycin [ ] Other(s) _____

Other Allergies / Sensitivities? _____

Child (Past Medical History)		FAMILY HISTORY (if yes, who?)	
Cataract	[ ] YES [ ] NO	[ ] YES [ ] NO	_____
Glaucoma	[ ] YES [ ] NO	[ ] YES [ ] NO	_____
Blindness	[ ] YES [ ] NO	[ ] YES [ ] NO	_____
Diabetes	[ ] YES [ ] NO	[ ] YES [ ] NO	_____ _____
Hypertension	[ ] YES [ ] NO	[ ] YES [ ] NO	_____
Heart Disease	[ ] YES [ ] NO	[ ] YES [ ] NO	_____
Arthritis	[ ] YES [ ] NO		
Neurologic Disease	[ ] YES [ ] NO		
Ear/Nose/Throat Disease	[ ] YES [ ] NO		
Gastro-Intestinal Disease	[ ] YES [ ] NO		
Hematological Disease	[ ] YES [ ] NO		
Skin Disease	[ ] YES [ ] NO		
Respiratory Illness	[ ] YES [ ] NO		
Asthma	[ ] YES [ ] NO		
High fevers	[ ] YES [ ] NO		
Tubes in the Ears	[ ] YES [ ] NO		

Other_____

_____

NOTICE OF PRIVACY PRACTICES – CONSENT

Dr. Joseph Audia & Associate • 2403 W Main Street • Salem, WV 26426 • 304-782-1005 • 304-782-3303 (Fax)
Dr. Joseph Audia & Associate • 345 Floral Drive • Harrisville, WV 26362 • 304-643-2117 • 304-643-2116 (Fax)

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Effective February 10, 2003

Patient name _____

Name (as you prefer to be called) _____ Parent's Name (if minor) _____

Patient address _____

City _____ State _____ Zip _____ E-Mail Address _____

Phone (Home) _____ Phone (Work) _____ Phone (Other) _____

Patient Social Security Number _____ Patient's Date of Birth _____

Occupation _____ Hobbies _____ Optical Insurance_____

Medical Insurance _____ Method of Payment [ ] Cash [ ] Check [ ] Visa [ ] MasterCard [ ] Insurance

How Did You Hear About Our Office? [ ] Been Patient Here Before [ ] Radio [ ]TV [ ] Newsletter [ ] Other _____
[ ] Doctor_____ [ ] A Friend_____ [ ] By Family_____ [ ] Our Staff_____ [ ] Insurance Company
[ ] Newspaper [ ] Exponent / Telegram [ ] Herald – Record [ ] Shinnston News [ ] Pennsboro News [ ] Ritchie County Gazette
[ ] Yellow Pages [ ] Bell Atlantic (Clarksburg) [ ] Armstrong Directory [ ] Mountaineer Country

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our Web site.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

EYEGLASS MATERIAL There are many various materials that can be used to fabricate eyeglass lenses. We discourage the use of glass lenses, as they are the **HEAVIEST** and **LEAST SAFE** to wear. We recommend plastic. When safety is a major concern (industrial safety glasses, sports goggles, etc.), polycarbonate plastic is the **MOST IMPACT RESISTANT** material to use. Please ask us if you have any questions about your material choices.

DILATED RETINAL EVALUATION In order to provide the most thorough eye exam possible, we routinely dilate the pupil. This is done at all complete exams and at many emergency office visits. Although we realize that many of our patients drive themselves after the exam, we recommend that someone else drive you if possible.

My signature on this form will serve as a " SIGNATURE ON FILE " for processing any applicable insurance claims. I realize my insurance may deny benefits if it feels I have received examination too frequently or received exams by more than one doctor for the same illness. I agree to pay for services and / or materials, which I order but my insurance does not cover. **With the exception of Medicare and Medicaid claims, I will pay directly to this office any unpaid insurance claim that reaches 60 days past due.** I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

I ACKNOWLEDGE THAT I RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR THIS OFFICE.

_____ _____
Dated Patient

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

_____ _____
Relationship to Patient Print Name

_____
Source of Authority

THANKS FOR SELECTING US TO PROVIDE YOUR CARE!

Please complete both pages and present them prior to your child's appointment