



**Behavioral Optometry • Vision Therapy and Rehabilitation
Samantha Slotnick, OD, FAAO, FCOVD**

495 Central Park Ave • Suite 301, Scarsdale, NY 10583 • (914) 874-1177 • www.DrSlotnick.com

WELCOME to the office of Dr. Samantha Slotnick. All information will be kept confidential.

TODAY'S DATE: _____
Mrs. / Mr. / Sr. / Rev. / PhD / MD / MS

Ins card(s) copied front/back ABN signed?
 Records Release filed? Y/N Referral Needed? Y/N

Patient's Last Name: _____ First Name _____ M.I. _____

Sex: M / F Age: _____ Birthdate: ____/____/____ *MARITAL STATUS* M / S / D / DP / W

Address: _____ Home # () _____
 Permission to txt appt confirm'n?

City _____ State _____ Zip _____ Cell # () _____

Email: _____ Best Contact # __H / __W / __Cell / __E-mail

Occupation _____ Employer _____

Work Address _____ Work # () _____

Spouse/Partner's Name _____ Cell # () _____

Email _____ Other # _____ Best Contact # __H / __W / __Cell / __E-mail
In case of emergency notify:

Name _____ Phone # () _____ Relationship _____

New patients: Who referred you? _____

ALL INSURANCE CARDS AND VISION COVERAGE MUST BE PRESENTED BEFORE SERVICES ARE RENDERED. PROOF OF MEDICAL INSURANCE DOES NOT GUARANTEE PAYMENT BY THE INSURANCE COMPANY. PLEASE BE AWARE THAT:

- 1) MEDICAL INSURANCE DOES NOT COVER NON-MEDICALLY RELATED VISION EVALUATIONS.
- 2) VISION PLANS DO NOT COVER NON-ROUTINE OCULAR HEALTH (MEDICAL) SERVICES.

Medical insurance Information

Insurance Company _____

Member or Primary Insured's I .D. # _____ Group number _____

Primary Insured's name: _____ DOB _____

Relationship to Patient: _____

I request that payment of authorized insurance be made to Dr. Samantha Slotnick for any services rendered. I authorize any holder of medical information about me, to release to HCF and its agents any information needed to determine these benefits payable for related services. I also understand there may be procedures that are not covered by my insurance and I am responsible for payment, including but not limited to refraction. I understand that payment in full is expected when services are rendered and materials dispensed.

SIGNATURE _____ Date _____

HIPAA privacy acknowledgement - I was given and read, and understand my privacy rights under the HIPAA laws.

Signature _____ Date _____



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ADULT VISION QUESTIONNAIRE - EXTENDED

Please fill out this questionnaire carefully. Please return it to our office prior to your appointment.

Email: Jane@DrSlotnick.com Fax: (914) 885-1463. THANK YOU.

Appointment: Day _____ Date _____ Time _____
Patient's Name: _____

GENERAL INFORMATION

Full Name: _____ Male Female

Birth Date: _____ Age: _____

Home Address: _____

Home Phone: _____ Work Phone: _____

Marital status: Single Married Divorced Widowed

Were you referred to our office? Yes No

If yes, whom may we thank for this referral? _____ Phone: _____

Address _____

Do you have Major Medical Insurance? Yes No

If yes, who is the carrier? _____ Policy #: _____

Does the insurance cover eye examinations or glasses? Yes No

Name of Insured: _____

Social Security Number: _____ Driver's License No.: _____

What is your occupation? _____ Employer: _____

Business Address: _____

Spouse's Name: _____ Occupation: _____

Spouse's Employer: _____ Phone #: _____

Business Address: _____

Please list your spouse and dependents:

NAME

Spouse _____ Birth Date _____

Dependent _____ Birth Date _____

Dependent _____ Birth Date _____

Dependent _____ Birth Date _____

Dependent _____ Birth Date _____

MEDICAL HISTORY

Date of most recent evaluation: _____ Physician's Name: _____

For what problem / condition? _____

Results and recommendations: _____

Medications currently using including vitamins and supplements: _____

For what condition(s)? _____

Are you allergic to any foods or medications? Yes No

If yes, please list: _____

Current diet: Excellent Good Fair Poor

Current state of health (explain): _____

Is there any history of the following? (please check if there is a history)

	<u>Patient</u>	<u>Family</u>	<u>Who</u>		<u>Patient</u>	<u>Family</u>	<u>Who</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Strabismus / crossed eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Amblyopia / lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>	_____

VISUAL HISTORY

Have you had a previous vision examination? Yes No
 If yes, doctor's name: _____
 Date of last visit: _____
 Reason for examination: _____
 Results and recommendations: _____

Were glasses, contact lenses, or other optical devices prescribed or recommended? Yes No
 If so, what? _____
 Do you use them? Yes No
 How long have you had them? _____
 If used, when? _____
 If not, why not? _____

If you wear contact lenses, how long have you worn them? _____
 What type of lenses do you have (i.e. hard, soft, gas-permeable)? _____
 What solutions do you use? _____

Members of the family who have had visual attention and the reason:

<u>Name</u>	<u>Age</u>	<u>Visual Situation</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

PRESENT SITUATION

Why do you feel the need for a visual evaluation? _____

 How long has this problem/difficulty existed? _____

Do you experience any of the following:

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
Blurred vision at distance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision at near	<input type="checkbox"/>	<input type="checkbox"/>	_____
Red or itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Sties	<input type="checkbox"/>	<input type="checkbox"/>	_____
Watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes hurt	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes feel tired	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nausea associate with visual tasks	<input type="checkbox"/>	<input type="checkbox"/>	_____

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
Halos around lights	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision at distance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision at near	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tilt head during desk work	<input type="checkbox"/>	<input type="checkbox"/>	_____
Squinting, covering or closing one eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Postural changes when doing desk work	<input type="checkbox"/>	<input type="checkbox"/>	_____
Need for very bright light when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Need for very dim light when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of interest or short attention span for close work	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty sustaining reading / writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
General or visual fatigue at the end of the day	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of place often when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skip lines when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Repetition of letter or words when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Omission of words when reading / copying	<input type="checkbox"/>	<input type="checkbox"/>	_____
Use of finger to keep place	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head moves when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Confusion of what is being seen or read	<input type="checkbox"/>	<input type="checkbox"/>	_____
Falling asleep when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Silent vocalization/moving lips while reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Motion / car sickness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with reading comprehension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Comprehension decreases over time	<input type="checkbox"/>		_____
Letters or words appear to move or float around when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty aligning columns of numbers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Can respond better orally than in writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Write or print poorly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor time management	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inconsistent performance in work or sports	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor general coordination / clumsiness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor fine motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulties with short-term memory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulties with long-term memory	<input type="checkbox"/>	<input type="checkbox"/>	_____

Comments on any items above: _____

COMPUTERS

Do you use a computer in your work, school, or leisure time activities? Yes No

If so, indicate the types of computer work you perform:

- Word processing
- Programming
- Data entry
- Internet
- Games / Leisure activities
- Other (explain): _____

How many hours do you spent in front of a computer screen each day? _____

How do your eyes feel after working at the computer? _____

- Where is the top of the screen located?
- Above your straight-ahead eye level
- At eye level
- Below eye level

What is the distance from: Your eyes to the screen? _____

Your eyes to the keyboard? _____

Your eyes to your source documents? _____

Where is the computer screen located?

- Directly in front of you when seated
- To your right
- To your left

Where are your source documents located?

- Directly in front of you when seated
- To your right
- To your left
- Flat (horizontal) or vertical

Do you experience any of the following lighting problems in your work area?

- Glare from windows or other light sources
- Reflections on your computer screen
- Difficulty reading source documents

Do you wear glasses, contact lenses, or other optical devices for computer work?

- Glasses
- Contact lenses
- Other (explain): _____

COMPUTERS (continued)

Please describe any problems you have with your vision, current glasses or contact lenses for computer work: _____

EMPLOYMENT OR SCHOOL

Current position: _____ Major course of study: _____

How many hours daily do you spend at a desk? _____

How many hours daily do you spend reading or studying? _____

How many hours daily do you spend working at near distances? _____

Do you feel you are achieving to your potential in work or school? Yes No

Do you feel you are getting adequate return for the amount of effort you put into a task? Yes No

If no, please explain: _____

Does your work or course of study demand comprehension from the written word? Yes No

Describe briefly your daily activities at work or in school: _____

HOBBIES/SPORTS

Describe the types of activities that comprise the majority of your leisure time: _____

Do you watch TV? Yes No

If yes, how many hours per day? _____

How many days per week? _____

Are you seriously involved with athletics? Yes No

Do you feel you are achieving up to your potential in sports/athletics? Yes No

Of all the sports you have played:

List the ones in which you excel: _____

List the ones in which you do poorly/avoid: _____

RELEASE OF INFORMATION AND INSURANCE FILING

It is often beneficial for us to discuss examination results and to exchange information with other professionals involved in your care. Please sign below to authorize the release of information.

I agree to permit information from, or copies of, my examination records to be exchanged with other health care providers or provided to insurance carriers upon their written request or upon the recommendation of Dr. Samantha Slotnick when it is necessary for the treatment of my visual condition, or for the processing of insurance claims. This authorization shall be valid for the duration of treatment.

X

Signature or Authorized Representative

Date

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation related to your specific visual needs.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us.

You may leave a message for us 24 hours a day /7 days a week.

CANCELLATION POLICY:

Your extended appointment time with the doctor is reserved expressly for you. There is a \$50 Cancellation Fee for all appointments cancelled/rescheduled within 48 hours of the appointed time. If you need to modify, cancel or reschedule your appointment, please be sure to make your request via email no less than 48 hours in advance: Jane@DrSlotnick.com

Please INITIAL HERE to acknowledge consent: X

Please arrive *15 minutes early* for your first examination to finish office registration, so that we will have the maximum opportunity to evaluate your visual status.
We are looking forward to meeting you.

Thank you.

Sincerely

Samantha Slotnick, O.D., F.A.A.O., F.C.O.V.D.
Clinical Director