Dr. Scott i. Morrison
OPTOMETRY, P.C.

Scott I. Morrison, O.D, F.A.A.O. · The Professional Center · 243 Main Street · Suite 120 · New Paltz, NY 12561 · (845) 255-4696
2294 Route 208, Suite 7 · Montgomery, NY 12549 · (845) 778-3591

PATIENT INFORMATION			
Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**	**Age:**
Preferred Name:	**Soc. Sec. #:**		
Street Address:	**City:**	**ST:**	**Zip:**
Home Phone:	**Cell Phone:**	**Work Phone:**	
Preferred Language: ☐ English ☐ Spanish	**Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Native Hawaiian/Other Pacific Island	**Race:** ☐ White ☐ Black or African American ☐ Hispanic ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian/Other Pacific Island	
Communication Preference: ☐ Email ☐ Postal ☐ Telephone	**Referred by:** ☐ Patient ☐ Doctor ☐ Insurance	**Ref. Name:**	
Email address:	**Email OK:** ☐ Yes ☐ No	**Text Message OK:** ☐ Yes ☐ No	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Emergency Contact:	**Phone:**		
Occupation:	**Employer:**		
Primary Care Physician:	**Phone:**		
Special Vision Requirements:			
Sports/Activities:			

INSURANCE INFORMATION					
Is this Patient under 18 years of Age? ☐ Yes ☐ No	If yes, please complete the Person responsible for bill section				
Person responsible for bill	**Date of Birth** / /	**Address (if different):**		**Home phone no.** ( )	
Is this person a patient here? ❑ Yes ❑ No If yes, indicate patients name:					
Primary Insurance Carrier Name:					
Subscriber's name:	**Subscriber's S.S. #:**	**Birth date:** / /	***Group no.:***	***Policy no.:***	***Co-payment:*** $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Secondary Insurance Carrier Name:					
Subscriber's name:	**Subscriber's S.S. #:**	**Birth date:** / /	***Group no.:***	***Policy no.:***	***Co-payment:*** $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

CONCERNING INSURANCE

Patients who are a member of a plan with which we participate are responsible at the time of service for all co-pays, deductibles and non-covered services and materials. Patients who are members of a plan with which this office does not participate are fully responsible for all procedures and materials at the time of service. Medicare patients are responsible for their refraction, all materials and charges applied to their deductible and 20% of the office fees once the deductible has been satisfied.

I have read the above and fully understand my financial responsibilities for all services and materials received in this office.

Signature:	**Printed Name:**	**Date:**

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Pediatric Optometry History Form

Date of last eye exam:_____Previous doctor's name:_____

Were your child's eyes dilated? Y N

Does your child wear glasses? Y N Age first worn: _____ contact lenses? Y N

Who is your child's pediatrician?_____City:_____

Medications and reason for taking:__ _____

Allergies to medications:_____

Surgery/Hospitalization:_____

What is the reason for this appointment?_____

Visual History

Blurry vision	Y	N	Tearing/discharge from the eyes	Y	N
Double vision	Y	N	History of eye surgery	Y	N
Head injury	Y	N	History of eye injury	Y	N
Flashes of light	Y	N	History of eye turn	Y	N
Floaters/spots in front of your eyes	Y	N	History of lazy eye	Y	N
Eye pain	Y	N	Eye strain	Y	N
Headaches	Y	N	Discomfort on computer	Y	N
Burning eyes	Y	N	Eye fatigue	Y	N
Itching eyes	Y	N	Poor concentration while reading	Y	N
Red eyes	Y	N	Vision worse at end of day	Y	N
Trouble copying from the board	Y	N	Trouble with visual memory	Y	N
Reversing letters	Y	N	Confusing words with similar beginning	Y	N
Sloppy handwriting	Y	N	Loss of place when reading/skipping	Y	N
Fall asleep while reading	Y	N	Close an eye when reading	Y	N
Turn/tilt head when reading	Y	N	Words run together when reading	Y	N
Temporary blur after reading	Y	N	Blur after reading for prolonged periods	Y	N
Headaches after prolonged reading	Y	N	Unable to read as long as desired	Y	N
Car sickness	Y	N	Social problems	Y	N
Attention problems	Y	N	Other		

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Medical History

General (fever, delayed growth, etc.)	Y	N	Skin (acne, warts, eczema, etc.)	Y	N
Ear, Nose, Throat (sinus, ear infections)	Y	N	Allergic/immunologic (hay fever, lupus etc.)	Y	N
Cardiovascular (heart murmur or defect)	Y	N	Psychiatric (behavior, ADHD, autism)	Y	N
Respiratory (asthma, etc.)	Y	N	Endocrine (diabetes, hypothyroid, etc.)	Y	N
Gastrointestinal (diarrhea, vomiting, etc.)	Y	N	Blood/Lymph (sickle cell, blood disorder)	Y	N
Genital, Kidney, Bladder	Y	N	Neurological (seizures, balance, etc.)	Y	N
Muscles, Bones, Joints (arthritis, etc.)	Y	N	Cancer	Y	N

Birth/Development History

Child is: Natural Adopted Foster

Length of pregnancy ____ weeks Birth Weight _____

Birth was: Natural Planned C-section Emergency C-section Suction/Forceps

Complications before/during/after birth:_____

Check if child was delayed in:

sitting _____ crawling _____ walking _____ talking _____

Educational History

School/Preschool/Child Care_____ Grade_____

On grade level for reading? Y N On grade level for math? Y N

My child has an IEP Y N My child has a 504 plan Y N

Pycho-educational testing	Y	N	Occupational therapy	Y	N
Physical therapy	Y	N	Speech therapy	Y	N
Psychological testing/therapy	Y	N	Neurological testing	Y	N

Family history

Lazy eye	Y	N	Dyslexia	Y	N
Autism Spectrum	Y	N	Genetic Disorders	Y	N