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 / X 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: *Support@DrSlotnick.com* ***Fax:*** *(914) 885-1463.* ***THANK YOU.***

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

GENERAL INFORMATION

Full Name: _____ Male ☐ Female ☐ Non-Binary ☐
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)

	Patient	Family	Who		Patient	Family	Who
Diabetes	☐	☐	_____	Strabismus / crossed eye	☐	☐	_____
Multiple Sclerosis	☐	☐	_____	Amblyopia / lazy eye	☐	☐	_____
Blindness	☐	☐	_____	Thyroid Condition	☐	☐	_____
Glaucoma	☐	☐	_____	Cataracts	☐	☐	_____
High Blood Pressure	☐	☐	_____	Brain Tumor	☐	☐	_____

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? _____

History of eye surgery? _____

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

Name	Age	Visual Situation
_____	____	_____
_____	____	_____
_____	____	_____

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:

	Yes	No	If yes, when?
Blurred vision at distance	☐	☐	_____
Blurred vision at near	☐	☐	_____
Red or itchy eyes	☐	☐	_____
Burning eyes	☐	☐	_____
Frequent Sties	☐	☐	_____
Watery eyes	☐	☐	_____
Eyes hurt	☐	☐	_____
Eyes feel tired	☐	☐	_____
Headaches	☐	☐	_____
Nausea associate with visual tasks	☐	☐	_____

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

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: Support@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

Samantha Slotnick, OD, FAAO, FCOVD
495 Central Park Ave ● Suite 301
Scarsdale, NY 10583

Quality of Life Questionnaire

Name:_____ Date:_____

		Never	Seldom	Occasionally	Frequently	Always
1	I have blurred vision when looking at near objects.	0	1	2	3	4
2	I have double vision. (Seeing two objects rather than one.)	0	1	2	3	4
3	I have headaches with near work.	0	1	2	3	4
4	Words run together when I read.	0	1	2	3	4
5	My eyes burn, itch and water.	0	1	2	3	4
6	I fall asleep when I read.	0	1	2	3	4
7	I see worse at the end of the day.	0	1	2	3	4
8	I skip or repeat lines when reading.	0	1	2	3	4
9	I feel dizzy or sick to my stomach with near work.	0	1	2	3	4
10	I tilt my head or cover an eye when reading.	0	1	2	3	4
11	I have difficulty copying from the chalkboard.	0	1	2	3	4
12	I avoid reading and near work.	0	1	2	3	4
13	I leave out small words when reading.	0	1	2	3	4
14	I write uphill or downhill (My handwriting tends to slant up or down).	0	1	2	3	4
15	Columns of numbers appear misaligned.	0	1	2	3	4
16	I don't understand what I read.	0	1	2	3	4
17	I am poor in sports.	0	1	2	3	4
18	I hold my reading very close.	0	1	2	3	4
19	I have trouble keeping attention on reading.	0	1	2	3	4
20	I have difficulty completing assignments on time.	0	1	2	3	4
21	I often say, "I can't" before trying.	0	1	2	3	4
22	I avoid sports and games.	0	1	2	3	4
23	I have poor hand/eye coordination	0	1	2	3	4
24	I do not judge distance accurately.	0	1	2	3	4
25	I am clumsy.	0	1	2	3	4
26	I do not use my time well.	0	1	2	3	4
27	I do not do well in figuring out change (money).	0	1	2	3	4
28	I lose papers and belongings.	0	1	2	3	4
29	I have trouble with car/motion sickness.	0	1	2	3	4
30	I am forgetful with a poor memory.	0	1	2	3	4
	Totals:					
	20-24 points = suspect 25 points or more=refer for care Score:					

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Reservation Policy

It is an honor for our entire team to create personal relationships with our patients and their families. These relationships come from the ability to provide time for meaningful interactions with patients and caregivers, and sufficient appointment time for a comprehensive, whole-person approach to care.

All appointments are reserved.

A $45 reservation deposit will be applied towards your appointment, in full.

- Our scheduling software enables us to create tentative appointments with a 24-hour hold. These appointments may be **secured by reservation**.
  Tentative appointments are subject to removal, notified by email.
- We ask that as a courtesy, you notify us AS SOON AS POSSIBLE if you are unable to keep your appointment.
- While we do understand extenuating circumstances, **your Reservation Deposit will be forfeited if your appointment is cancelled OR rescheduled within 2 full business days of your appointment.**
  - Please note, *if you need to reschedule a* ***Tuesday*** appointment, please contact us by **Friday** to avoid forfeiting your reservation.
  - We offer to *return* any forfeited reservation deposit as a *credit on your account* when you keep *the next three* appointments without need of rescheduling.
- "Standing appointments" for Vision Therapy are already reserved, and managed with a separate policy.

Acknowledged: X_____, _____ _____

Sign Print Date

We are grateful for the opportunity to provide our patients and their families with time, care and support.

Sincerely,

Dr. Samantha Slotnick and Vision Team