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.

Adult Intake Form

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 # ( ) _____

Work Address_____

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?** _____

Do you exhibit any of these symptoms?

☐ **Headaches**	☐ **Clumsiness**	☐ **Flashing lights**
☐ **Eye Fatigue**	☐ **Difficulty judging distances**	☐ **Floating spots**
☐ **Avoidance of reading**	☐ **Poor depth perception**	☐ **Glare**
☐ **Loss of place when reading**	☐ **Balance problems**	☐ **Excessive tearing**
☐ **Poor reading comprehension**	☐ **Limited use of peripheral vision**	☐ **Excessive burning or redness**
Blurred vision: ☐ **With distance viewing** ☐ **With near work/ on the computer**	☐ **Double vision** ☐ **Difficulty with nighttime driving**	☐ **Itching eyes/ eyelids** ☐ **Other** _____ _____

Do you…?

☐ **wear contact lenses** ☐ **own a backup pair of glasses** ☐ **have sunglasses** ☐**own office/computer glasses**

☐**Have any hobbies/ pastimes? (sports/ music/ art/ needlepoint/ sewing/ models/ collections, etc.)** _____

_____

REASON FOR TODAY'S VISIT _____

_____

Date of your last Eye Examination: _____ Doctor's name/ location:_____

Have you ever had eye surgery? _____

Interested in contact lenses? Y ☐ N ☐ Interested in refractive surgery (e.g., LASIK)? Y ☐ N ☐ Hours on the computer/ day? _____

Current medications / vitamins supplements (please include OTC) _____

_____

Is there a **Family History** of (circle all applicable): **Allergies** to meds? Y ☐ N ☐ _____

High blood pressure / Diabetes / Glaucoma / Macular Degeneration / Lazy eye / Eye turn

Comments: _____

Physician's Name_____ Phone #: _____

Address_____

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: _____

RELEASE OF INFORMATION AND INSURANCE FILING

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 _____

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_____

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

Signature_____Date_____

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