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_____

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

Patient Information

Last Name: _____First Name _____M.I._____ Nickname _____

Sex: M / F / X Birthdate: _____ AGE____ Grade _____ School _____
○ ○ ○

Address: _____ City _____ State _____ Zip_____

Home # ( ) _____ Cell# ( ) _____ Email _____

Patient referred by: _____

Parents (or guardians):
Mother Name_____Cell #: _____Work#: _____
□ Permission to txt appt confirm'n?

Address (if different) _____

E-mail Address_____Best Contact # □H /□W/ □Cell/ □E-mail

Mother's Employer/Address_____

Father Name_____Cell #: _____Work#: _____
□ Permission to txt appt confirm'n?

Address (if different) _____

E-mail Address_____Best Contact # □H /□W/ □Cell/ □E-mail

Father's Employer/Address_____

In case of emergency notify:
Name _____ Phone # ( ) _____ Relationship _____

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.

Parent/Guardian Signature_____ Date_____

InfantSEE™ Confidential Infant History
Assessment Date: ____/____/____

Name: _____ Male ☐ Female ☐ DOB: ____/____/____

Home Phone: _____ Hispanic | Caucasian | African American | Native American | Asian | Pacific Islander

Home Address: _____
Street City State Zip Code

Parent(s) or Guardian(s): _____ Adult(s) Occupation: _____

How did you learn about our program? ☐Current patients ☐Referred by friends/family ☐Print Ads ☐Radio Ads ☐Website ☐Story in Newspaper/on TV ☐ Referred by Dr._____

Eye History

Have you ever noticed any of the following happening with your baby's eyes? (please check any that apply)

Eye turn: ☐ in ☐ out ☐ Eyes watering ☐ Eyes red ☐ Swelling around the eyes ☐ White appearance in pupil

Explain any eye concerns noted by observing child: _____

Developmental and Health History

PREGNANCY

Length of pregnancy: _____ weeks List any complications during pregnancy: _____

Other pregnancy issues: _____

DELIVERY

Birth Weight _____ Parents ages at time of birth: Mother _____ Father _____

List any complications during delivery: _____

Was oxygen used? ☐ No ☐ Yes APGAR score at birth: _____ (if known)

MEDICAL

Child's Doctor: _____ Last Exam Date: _____ Are immunizations up to date? ☐ Yes ☐ No

Does your baby have any known food or drug allergies? ☐ No ☐ Yes: _____

List ALL medications taken regularly: ☐ None List: _____

List any developmental delays: _____

Check all of the following that your baby can do at this time: ☐ Roll Over ☐ Sit ☐ Crawl ☐ Stand ☐ Walk

Has your baby ever had a high temperature (fever)? ☐ No ☐ Yes, how high? _____

Please list any childhood illnesses your baby has had:

_____ Illness _____ Age at the time. Was the illness? ☐ Mild ☐ Moderate ☐ Severe

_____ Illness _____ Age at the time. Was the illness? ☐ Mild ☐ Moderate ☐ Severe

List any accidents, eye, or head injuries, and age they occurred: _____

Please list any other conditions we should know about: _____

Family History

Do any family members have: Lazy eye (amblyopia) ☐Yes ☐No Eye turn (strabismus) ☐Yes ☐No Eye tumor ☐Yes ☐No

Please list any family members with a history of other eye or medical problems. List the relation and type of problem:

I acknowledge that this information is accurate to the extent that I can be certain, and will disclose additional information as necessary. This information can only be used in the management of my child's eyes and vision.

I understand that the InfantSEE™ vision assessment is without charge. If further services or treatments are recommended, I may choose any eye care professional to provide those services.

_____ Date: ____/____/____
Parent/Guardian Signature

Thank you for carefully completing this confidential questionnaire. This information will allow for a more efficient use of examination time and will contribute to the understanding of infant eye and vision development.