Richard E. Sorkin, O.D., F.A.A.O., F.C.O.V.D.

DOCTOR OF OPTOMETRY
• Fellow, American Academy of Optometry
• Residency Trained in Pediatrics and Vision Therapy
• Fellow, College of Optometrists in Vision Development

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Review of Systems:

Does your child currently have any of the following problems?

Chronic fever, unexplained weight loss/gain, chronic fatigue..... YES ☐ .....NO ☐
If YES, please explain:_____

Ear/Nose/Throat problems (i.e. hearing loss, sinus problems).....YES ☐ .....NO ☐
If YES, please explain:_____

Heart Problems (i.e. chest pain, irregular heart beat)..... YES ☐ .....NO ☐
If YES, please explain:_____

Respiratory Problems (i.e. shortness of breath, chronic cough)..... .YES ☐ .....NO ☐
If YES, please explain:_____

Gastrointestinal Problems (i.e. heartburn, abdominal pain, prostate cancer)...YES ☐ .....NO ☐
If YES, please explain:_____

Urinary Problems (i.e. blood in urine, pain)..... YES ☐ .....NO ☐
If YES, please explain:_____

Skin Problems (i.e. rashes, eczema, new moles or growths)..... YES ☐ .....NO ☐
If YES, please explain:_____

Musculoskeletal Problems (i.e. arthritis, osteoporosis)..... YES ☐ .....NO ☐
If YES, please explain:_____

Neurological Problems (i.e. headaches, seizures, stroke)..... YES ☐ .....NO ☐
If YES, please explain:_____

Psychiatric Problems (i.e. depression, anxiety)..... YES ☐ .....NO ☐
If YES, please explain:_____

Family and Social History:

Do any MEDICAL or EYE diseases run in the family? Please circle and list family member:

Glaucoma_____ Diabetes_____
High Blood Pressure_____ Cataracts_____
Cancer_____ Macular Degeneration_____
Amblyopia/ Lazy Eye_____ Strabismus/ Eye Turn_____

Do any Learning Related Disabilities run in the family? Please circle and list family member:

ADD/ADHD_____ Sensory Processing Disorders_____
Other _____

Has Your Child Received any of the Following:

Psychoeducational Testing: _____
Occupational/Speech/Physical Therapy: _____
Gifted Program: _____
Classroom Accommodations: (504/IEP/Tutoring): _____

Signature: _____ Date: _____

Patient's Name:_____ Date:_____

We appreciate you choosing our office for your eye care needs. To better serve your child, please answer the following questions:

Parent/Guardian Names:_____

1. Does your child wear eyeglasses or contact lenses?
   Eyeglasses: YES ☐ NO ☐ Contact Lenses: YES ☐ NO ☐

2. Does your child experience any eye symptoms? Please circle all that apply:

Blurred Vision	Light Sensitivity	Eye Pain/Discomfort
Double Vision	Reading Discomfort	Falling Asleep Reading
Motion Sickness	Red/Burning/Itchy/ Eyes	Discomfort with 3D Movies
Squinting	Winks or Closes One Eye	Frequent Styes/ Infections

2. Does your child currently use a computer/tablet/cell phone? YES ☐ NO ☐
If so, indicate how many hours per day:_____
_____

4. Has your child ever had EYE surgery or any EYE disease? YES ☐ NO ☐
If so, please describe:_____
_____

5. Has your child ever had an EYE injury or trauma? YES ☐ NO ☐
If so, please describe when and how:_____
_____

6. When was your child's last eye exam?_____ Dr.'s Name:_____

7. When was your child's last physical examination?_____ Dr.'s Name:_____

8. Has your child ever been treated for any medical conditions (diabetes, high blood pressure, etc.)?
YES ☐ NO ☐ If YES, please explain: _____
_____

9. Is your child currently using any medications? YES ☐ NO ☐ If so, please list the medications and how often they are used:_____
_____

10. Is your child allergic to any medications? YES ☐ NO ☐ Please list:_____
_____

Dr. Richard Sorkin, O.D., F.A.A.O, F.C.O.V.D.

Patient Data Sheet

Patient Information	Insurance Information
Name _____	Insurance Company _____
Address _____	Group # _____
City _____ Zip _____	Subscriber Name _____
Phone _____	
Date of Birth _____	Referred by _____
Social Security # _____	
Email Address _____	

Assignment and Release

- I, the undersigned, certify that I (or my dependent) have insurance coverage with the above name company and assign directly to Dr. Sorkin's Office all insurance benefits, if any, otherwise payable to me for services rendered.
- I understand that insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment.
- I understand that I am financially responsible for all charges whether or not paid by insurance. Dr. Sorkin's office will submit an insurance claim as a courtesy. However, if that claim is denied **for any reason**, I am responsible for payment of all applicable fees.
- Certain ophthalmic tests like refractions are an integral part of a complete eye exam. However, many insurances such as Medicare consider this "routine eye care" and not a covered medical service. I understand that I am financially responsible for all charges for these non-covered medical services.
- I authorize the use of this signature on all insurance submissions.
- I hereby authorize the doctor to release all information necessary to secure the payment of benefits.
- I acknowledge that I have received your Patient Information Privacy notice.

X _____ _____

Patient Signature/or Guardian signature if minor — Date

INFORMED ACKOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I, _____, have reviewed a copy of this office's Notice of Privacy Practices and I am aware
Patient (if 18 yrs+)/Guardian

that the office has a copy of the Notice available to take with me if I request one.

X _____ _____ _____

Signature — Please print name — Date

For Office Use Only

We attempted to obtain written proof of Informed Acknowledgement of Notice of Privacy Practices, but Acknowledgement could not be obtained because:

[ ] Individual refused to sign [ ] Communication barriers prohibited obtaining the acknowledgement
[ ] an emergency situation prevented us from obtaining acknowledgement [ ] Other (Please specify)