Dawn P. Rush, MD

Renee Richards, MD * Nechama Mina Shoshani, MD * Jill Chafitz, OD

Pediatric Ophthalmology & Adult Strabismus

2649 Strang Boulevard, Suite 203 * Yorktown Heights * New York * 10598

Patient's Last Name_____ First Name_____ MI____

Date of Birth_____ Age_____ Sex: F M Race:_____ Language_____

Address_____ Apt #___ City_____ State___ Zip_____

Home Phone:_____ Day Phone:_____ Cell Phone:_____

Emergency Contact:_____ Relationship_____ Phone:_____

Primary Care Physician_____ Referring Physician_____

Pharmacy:_____ Location:_____ Tel #_____

Email:_____

Please list all family members seen in this office:

Name_____ DOB_____ M F
Name_____ DOB_____ M F
Name_____ DOB_____ M F
Name_____ DOB_____ M F

Name_____ DOB_____ M F
Name_____ DOB_____ M F
Name_____ DOB_____ M F
Name_____ DOB_____ M F

Primary Medical Insurance: **Does your insurance require a referral? Y N**

Policy Holder Name_____ DOB_____ Relationship_____

Insurance Carrier_____ Policy #_____ Group #_____

Employer:_____ Occupation_____ Co-Pay Amount_____

Secondary Medical Insurance: **Does your insurance require a referral? Y N**

Policy Holder Name_____ DOB_____ Relationship_____

Insurance Carrier_____ Policy #_____ Group #_____

Employer:_____ Occupation_____ Co-Pay Amount_____

Pediatric Only:

Mother's Name_____ Address_____ Phone_____

Father's Name_____ Address_____ Phone_____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. I have recieved **Dawn P. Rush, MD PLLC notice of privacy practice.**

*Responsible Party Signature:*_____ *Date:*_____

Medical History Questionnaire

Does Your Child:

Have brothers?_____ Sisters? _____(How Many)

Has another child of yours seen one of our doctors in the past?

_____

Significant medical history?_____

Take any medications? N Y_____

Dosage?_____

Have any allergies to medications? N Y_____

Birth History:

Was Your child premature? N Y

Birth Weight_____# of weeks early?_____

Any Problems with the pregnancy or delivery? N Y

_____

_____

(Please circle one) Delivery? Vaginal C-Section

Is your child Adopted? N Y

Reaction To Medication: Please Fill In Circles

Location	Skin O	Local O	Abdominal O	Systemic O		
Reaction	Rash localized O	Rash Generalized O	Itchy O	Patchy-Swelling O	Facial-Swelling O	Hives O
Severity	Very Mild O	Mild O	Moderate O	Severe O		

Eye History:

Main reason for appointment today? _____

Does your child's eye(s) turn in or drift out? N / Y

Does your child wear glasses now/ past? N / Y

Has your child worn bifocals? N / Y

Has your child had eye surgery? if yes when_____

Do you patch your child's eye now? N / Y

Does Your child have a habitual head tilt? N / Y

Does your child wear contacts? N / Y

Past Surgical History:

List any surgical procedures and dates:

Does your child have any problems with: Please complete entire Medical History Form

Eyes other than listed above? N Y_____

Developmental Delays? N Y_____

Recent Trauma? N Y_____

Chromosome abnormalities or syndromes? N Y_____

N Y Endocrine N Y Stomach N Y Blood N Y Allergies: allergic to _____

N Y Diabetes N Y Gastrointestinal N Y Lymphatic system N Y Immunologic

N Y Ears N Y Muscle N Y Genital N Y Psychiatric N Y ADD N Y PDD N Y Fevers N Y Skin

N Y Nose N Y Bones N Y Kidney N Y Neurological N Y ADHD N Y Cerebral Palsy N Y Weight Gain

N Y Throat N Y Joints N Y Bladder N Y Headaches N Y Autism N Y Seizures N Y Weight Loss

N Y Heart Disease N Y Thyroid Disease N Y Cardiovascular:_____

N Y Lung Disease N Y Anemia N Y Cancer:_____

Family History: Does the Mother Father Any Grandparent or Sibling have any of the following?

AMBLYOPIA STRABISMUS LAZY EYE ADVERSE REACTION TO ANESTHESIA GLAUCOMA

Any other heritable disease:_____

Family history of childhood eye problems:_____

Does anyone in the family wear glasses? Y N Who?_____as a child? Y N

Social History: Does your child: Attend school? Y N Have difficulty learning? Y N

is your child in Special Education? Y N Use Tobacco? Y N

PATIENT:_____M/ F DOB:_____Age:_____Date:_____

Physicians signature:_____ Date:_____

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Acknowledgment

I _____acknowledge that I am financially responsible for non-covered services.

I hereby authorize the office of **Dawn P. Rush, MD PLLC** to keep my signature on file and to charge my Credit card as indicated below:

Balance of charges not paid by insurance to include:
Copays, coinsurance, deductibles, refraction charges $45.00, visual field exams, fundus photography, supply of contact lenses etc...

Any administrative charges for no show appointments $75.00 during the week
$100.00 on weekends

I assign my insurance benefits to the provider listed above. I understand that this form will be shredded after the document has been secured in our system. If I need to cancel the authorization for this credit card I will give written consent to the healthcare provider.

Patient Name:_____
Cardholder Name:_____
Cardholder Billing Address:_____
City_____State_____Zip_____

Please check one ( ) MasterCard ( ) Visa ( ) Discover

_____-_____-_____-_____Expiration Date ____/____
Account Number MO YR

Cardholder Signature: _____

Date:_____

Our office policy requires a credit card to be on file for services

If you choose not to fill out this form please state why.

_____
_____
_____