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 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.