DEVELOPMENTAL
& BEHAVIORAL
OPTOMETRISTS

PAULINE K. BUCK, OD, F.C.O.V.D., F.A.A.O

WELCOME TO OUR OFFICE.

WE THANK YOU FOR CHOOSING US. DR. BUCK AND STAFF

Print Name (Last) _____ (First) _____

Address_____

City/State _____Zip Code _____

Home Phone (___) _____

Work Phone (___) _____

Cell Phone (___) _____

Social Sec. ____-____-_____

Email Address _____

Occupation _____ Employer_____

Date of Birth _____

Marital Status ____ If Child, Parent's Name_____

Name of Primary Care Physician/Pediatrician _____Phone_____

What is the reason for your visit?_____

Insurance Name:_____Insurance ID#:_____

Primary Holder:_____

How did you find out about our office?_____

If someone referred you please indicate name: _____.

May we use your name in thanking that person? Yes____ No _____

4770 Biscayne Blvd Suite #550 Miami, Florida 33137
Phone: (305) 576-5338 Fax: (305) 576-5366
www.drbuckvisiontherapy.com paulinekbuck@bellsouth.net

Enabling success through visual development

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Individually Identifiable Health Information Privacy Policy

Dr Buck's office has applied reasonable safeguards and implemented standards with respect to the primary use or disclosure of individually identifiable health information. We have in place appropriate administrative, technical, and physical safeguards that protect against uses and disclosures of information not permitted by the privacy rule, as well as that limit incidental uses or disclosures.

For example, we have counseled our staff in such measures as:
- to speak quietly when discussing a patient's condition with family members in a waiting room or other public area;
- to avoid using patients' names in public hallways and elevators, and posting signs to remind employees to protect patient confidentiality;
- to isolate or locking file cabinets or records rooms;
- to provide additional security, such as passwords, on computers maintaining personal information.

We also limit who has access to protected health information, and under what conditions, based on job responsibilities and the nature of the business.

Additionally, Dr Buck's office obtains satisfactory assurances from its business associates that the business associates will appropriately safeguard the protected health information it receives or creates on behalf of the covered entity.

Dr Buck may share information with other covered entities for the purposes of providing treatment. Treatment generally means the provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another. The Privacy Rule permits covered entities to disclose protected health information, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability.

Dr Buck may occasionally send information discussing new treatment options or products. We will not disclose individual health information in any of these marketing communications. Dr Buck has a policy of providing patients with a courtesy reminder of appointment times and/or order status either via telephone, printed or electronic communication. We will not release any products or information regarding a patient to another individual without verbal or written consent from said patient.

Acknowledgment

I have been notified of, and agree to, Dr Pauline Buck's conformance to the Standards for Privacy of Individually Identifiable Health Information.

_____

Print Name

_____

Signature Date

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Neurodevelopmental patient history

This questionnaire will allow us to plan for your appointment, and will give us much background information about your child. Please fill in as fully as you are able.

Child's name

Date of Birth

Please use the space below to explain your chief concerns that have led you to seeking our help.

Mother's name
Mother's occupation

Father's name
Father's occupation

Is your family a single or multiple household family?
Who is the primary caretaker?

Are there any siblings?
Please list names and ages.

Is your child adopted?
If so at what age?
From where?
Do they have any significant known past history?

Has your child's visual/behavioral condition affect family dynamics?

Who may we thank for your referral to us?

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Visual history

Has there been any previous visual care? yes / no

Please describe below in detail any orthoptic exercises, surgery, patching etc. that may have been used, including information on glasses. If you have a copy of the current spectacle prescription, please bring it with you to the exam.

If spectacles have been prescribed, are they still worn?

Prenatal history

Was your pregnancy full term? Were there any complications?
If yes please describe.

Were you active during the pregnancy?
What type of activities?

Were there multiple births?
Was the baby active in the womb?
Were there any complications at birth?
If so please describe.

Was the birth normal or c-section?
Was oxygen used after birth?

Was the hospital stay lengthened for any reason?

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Medical History

Who is the child's pediatrician?
Was your child ever hospitalized?
What was the reason for the hospitalization?

Did your child suffer any injuries i.e. a fall?
Did your child ever have a high fever?
Did your child ever have an ear infection?
Have there been any hearing problems?
If so, please detail...

Has your child been vaccinated?
When was the most recent vaccination?

Does your child have any allergies? or food sensitivity?
Please detail.

Is your child presently being treated for any condition?
Please detail.
Who is the doctor monitoring this condition?
What is the treatment for this condition?
Therapy?
Type
With whom?

Medications?
Please list

Is there a family history of health problems?
Please specify who and what

Is there a family history of eye problems?
Please specify who and what

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Is there a family history of learning/behavioral problems?
Please specify who and what

Developmental history

Is your child breast fed or bottle fed?
Did one side have more milk than the other?
Which?
If bottle fed did you alternate side on which your baby was fed?

Did you have a rocking chair that was used regularly?

Was your baby transported in a stroller or in a carrier that you wore?

Did your child crawl?
Was the crawl normal or unusual?
How long did your child crawl?

Has your child started
Walking? Age
Talking? Age
Sleeping through the night? Age

Does your child wet the bed?

A day in the life of your child

What do your child like to eat?
What doesn't your child like to eat?
Does your child drink water daily?

How many meals per week do you:
eat together as a family?

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eat out?
eat Fast food?

How many hours per day does your child:
Sleep?
Watch TV?
How far does your child sit from the TV?
Play video games?
Handheld?
TV based?
Play outdoors in unstructured play?
Play in organized group activities?

Is your child well coordinated?
What is your child's playtime game?

Can your child:
Ride a tricycle or bicycle?

Ride a scooter?

Play an instrument?

Does your child attend a preschool?
What school?

Thank you for taking the time to fill this out.
Email these forms to drbuck4770@hotmail.com or
Fax (305) 576 5366.
Once I have reviewed your responses I will have my assistant contact you to set up a time for us to speak before setting up your appointment.
I look forward to meeting you.

Dr. Buck

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