

Specialty Eyecare Group

InfantSEE Patient Information

Patient Name (F/M/L) _____ Birth date _____ Last 4# of SS# _____ Sex M / F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Parent's E-mail _____

*Parent/Guardian(s) _____ Parent Occupation(s) _____

Do you have siblings? If yes, please fill in below:

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

How Did You Find Out About Us? _____ Referred by _____

Insurance Verification & Privacy Statement

Vision Insurance Co. Name _____ Subscriber's Name _____

Relationship to Subscriber: Self / Spouse / Child Subscriber's ID/SSN# _____ Birth date _____

Medical Insurance Co. Name _____ Subscriber's Name _____

Relationship to Subscriber: Self / Spouse / Child Subscriber's ID/SSN# _____ Birth date _____

Authorization: I certify that I have read and answered the above information to the best of my ability

My signature below serves as a signature on file for billing and that I have been given an opportunity to review the HIPPA Privacy Act as it applies to my care with Specialty Eyecare Group.

Signature _____ Date _____

Insurance Coverage

In order to serve you better; please provide your insurance card(s) so we may make copies

In signing this statement I agree to be financially responsible for all charges. I understand that my insurance is not a substitute for payment and it is my responsibility to pay, in advance, the deductible, the co-pay and any other balance not paid by my insurance company. I also understand that verification of my benefits is not a guarantee of payment. Most insurance policies pay only a portion of the total fees. If you have questions about your coverage, please contact your insurance company. All accounts over 60 days will receive an interest charge of 1.5% per month (or 18% per year) on all unpaid balances.

I have had my insurance explained to me and have had an opportunity to ask questions. I understand that I am responsible for charges for services and products that are not covered by my insurance plan.

Signature _____ Date _____

Personal Eye History

Please Circle those that apply to your child:

Eye turns in / eye turns out

Eyes watering

Eyes red

Swelling around the eyes

White appearance in pupil

Other concerns _____

Health and Developmental History

Medical Doctor _____ Clinic _____ Phone _____

Other Doctor _____ Clinic _____ Phone _____

Medications (Rx and OTC) _____

Allergies to Medications _____ Other Allergies _____

Pregnancy: Full term / _____ wks early Birth Weight: _____ lbs Complications: No / Yes, Please note _____

Please circle all that your baby can do at this time: Roll over / Sit / Crawl / Stand / Walk

List any developmental delays or concerns _____

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

Please list any other conditions / childhood illnesses _____

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

Please Record who in the Family had/has these conditions:

Condition	Family Member(s)
Cancer, breast	
Cancer, lung	
Diabetes	
Heart Disease	
High Blood Pressure	
Stroke	
Thyroid disease	
Blindness	
Color Deficiency	
Cross eyed/Strabismus	
Amblyopia (lazy eye)	
Glaucoma	
Macular degeneration	
Retinal Tear/Detachment	
Other	



Dear Parent / Guardian:

InfantSEE[®], a public health program, managed by Optometry Cares[™] - the AOA Foundation, is designed to ensure that eye and vision care becomes an essential part of infant wellness care to improve a child's quality of life. Under this program, participating optometrists provide a one-time comprehensive infant eye assessment between 6 and 12 months of age as a no-cost public service.

If it is determined during the InfantSEE assessment that follow up care is needed for your child in the way of a comprehensive examination, treatment or therapy, you are free to choose any practitioner for these additional services. For a list of optometrists in your area, visit www.aoa.org or for additional information about the InfantSEE program call (888) 396-EYES (3937) or www.infantsee.org.

Thank you for choosing InfantSEE.

Infant Development during the First 12 Months

The first year of life is one of the most critical stages in childhood development. From the moment they open their eyes, newborns undergo dramatic physical and mental changes.

During the first 12 months, infants should be examined regularly to determine proper development and identify any health problems. Early detection and treatment of potential problems are vital to a child's development. The following developmental milestones should be monitored during routine well-care exams with the appropriate specialists.

	Vision	Speech & Hearing	Physical	Emotional & Social
By 3 Months	<ul style="list-style-type: none"> ▪ Tends to see objects about a foot away ▪ Follows moving objects and reaches for things 	<ul style="list-style-type: none"> ▪ Sucks and swallows ▪ Quiets and smiles in response to sound or voice 	<ul style="list-style-type: none"> ▪ Pushes up on arms ▪ Lifts and holds head up 	<ul style="list-style-type: none"> ▪ Needs to be cradled and comforted ▪ Begins to develop trust in parents or caregivers
By 6 Months	<ul style="list-style-type: none"> ▪ Eye movement and eye/body coordination skills develop ▪ Both eyes should focus equally 	<ul style="list-style-type: none"> ▪ Uses consonant sounds in babbling ▪ Uses babbling to get attention 	<ul style="list-style-type: none"> ▪ Uses hands to support self in sitting ▪ Rolls from back to tummy 	<ul style="list-style-type: none"> ▪ Smiles broadly and laughs when pleased ▪ Develops self-calming skills to quiet down after being upset
By 9 Months	<ul style="list-style-type: none"> ▪ Eye/body coordination skills develop further ▪ Eye contact begins to replace physical contact 	<ul style="list-style-type: none"> ▪ Increases variety of sounds and syllables ▪ Looks at familiar objects and people when named 	<ul style="list-style-type: none"> ▪ Sits and reaches for toys without falling ▪ Moves from tummy or back into sitting 	<ul style="list-style-type: none"> ▪ Gets angry and frustrated when their needs are not met ▪ Begins to fear strangers
By 12 Months	<ul style="list-style-type: none"> ▪ Uses both eyes to judge distances 	<ul style="list-style-type: none"> ▪ Says "mama" and "dada" 	<ul style="list-style-type: none"> ▪ Pulls self up to stand ▪ Stands alone and takes independent step 	<ul style="list-style-type: none"> ▪ Expresses a variety of emotions such as fear, anger, dislike and happiness

Sources: American Academy of Pediatrics, American Optometric Association – Your Baby's Eyes Brochure, Invest in Kids



InfantSEE® Clinical Assessment Form

<http://exam.infantsee.org>

Date of Exam ____/____/____

FOR PATIENT FILE USE ONLY

Infant Name: _____ D.O.B.: ____/____/____ Age: ____ Months

Parent/Guardian: _____ Premature? Yes ___ No ___ If yes: how many weeks ____

Gender: Male Female Ethnic Origin: Hispanic Caucasian African American Native American Asian Other

Reason for Visit:

- Requested InfantSEE® Assessment
- Referred; reported problem: _____

How did you find out about InfantSEE®?

- Current patients Friend/family Mail / print ads TV
- Radio ads Internet Newspaper
- Primary health provider Parenting classes
- Other, specify _____

Visual Acuity: Fix & Follow Method: OD Y N OS Y N
 Resistance to Occlusion: OD OS None
 10 Vertical Prism Test: Pass Fail
 OD _____ OS _____ OU _____ Teller Richman

Ocular Motility: Full Range of Motion (FROM) Motility Limitation: _____

Alignment / Binocular Potential:

Hirschberg: Aligned Misaligned _____
 Cover Test: Normal Alignment Strabismus: _____
 Phoria: _____

Convergence Estimate: Normal Inadequate
 10 Vertical Prism Test: Pass Fail
 Brückner Equal reflexes Whiter and Brighter: R L

Refractive Status: Manifest OD _____ Additional OD _____
 Retinoscopy OS _____ Retinoscopy OS _____

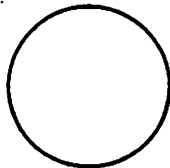
Mohindra Cycloplegic: Agent: _____

External/Anterior Segment Evaluation: Normal Problem Noted: _____

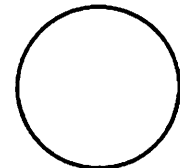
Visual Field Assessment: Full OU Full OD Full OS Problem Noted: _____

Pupil Evaluation: Normal Problem Noted: _____

Internal Assessment



CL Lens CL
 CL Vitreous CL
 Disc _____
 Vessels _____
 CL Macula CL
 + Foveal Reflex +
 Peripheral Retina _____



dilated non-dilated

ASSESSMENT (Use InfantSEE® Clinical Assessment Criteria)

- Ocular Motility No Concern Concern Problem _____
- Binocularity No Concern Concern Problem _____
- Refractive Status No Concern Concern Problem _____
- Visual Acuity No Concern Concern Problem _____
- Ocular Health No Concern Problem _____
- Plan No Concerns Concerns and in need of follow up care in ____ months or ____ weeks

Referral to: _____ Recommended follow-up: _____ years of age

OD Name/AOA Number	State	Zip Code	Date

For questions contact InfantSEE® Program: (800) 365-2219 ext. 4286 or infantsee@aoa.org



Ocular Motility

- No Concern – ability to look at the target, follow and maintain for a brief period or until something else captures the attention
- Concern – Reduced ability to gain visual attention in the primary position
- Problem - Any limitation of movement in the cardinal meridian

Binocularity (Cover Test Data)

- No Concern – stereo response on gross targets
- Concern – no response on stereo targets
- Problem – obvious or subtle strabismus

Refractive Status

1. Hyperopia

- No Concern – Less than +3.50 - discuss risk, what to watch for, and usually seen at age 3
- Concern – Between +3.50 and +5.00 - definite need to follow up within 6 to 12 months
- Problem – Over +5.00 - establish patient in an optometric office

2. Myopia

- No Concern - Less than -1.00 - discuss risk, what to watch for, and usually seen at age 3
- Concern – Slightly over -1.00 definite need to follow up within 6 to 12 months
- Problem – Well over -1.00 - establish patient in an optometric office

3. Astigmatism

- No Concern – Less than 2.00 - discuss risk, what to watch for, and usually seen at age 3
- Concern – 2.00 to 3.00 - Definite need to follow up within 6 to 12 months
- Problem – 3.00 – over 3.00 - Establish patient in an optometric office

4. Anisometropia

- No Concern – Less than 1.00 - discuss risk, what to watch for, and usually seen at age 3
- Concern – Between 1.00 and 2.00 - definite need to follow up within 6 to 12 months
- Problem – Over 2.00 - establish patient in an optometric office

Visual Acuity / Looking Behavior

- No Concern
- Concern – Reduced ability to look/fixate
- Problem – Fixation preference for one eye or Failed Visual Acuity test

Ocular Health

- No Concern
- Problem – any noted anomaly