

OPTOMETRY

Child's Name: _____

Today's Date: ____/____/____

Address: _____

Home Phone: _____

Grade in school: _____

Gender: Male Female

Head of Household: _____

Child's Birth Date: ____/____/____ SS#: ____/____/____

Emergency Contact: _____ Phone: _____

Last Medical Exam: ____/____/____ Name of Medical Doctor: _____ Phone: _____

Last Eye Exam: ____/____/____ Where: _____ Phone: _____

Parent's Name: _____

E-Mail: _____

Occupation: _____

Employer: _____

Insurance Information

Primary Insurance: _____

Policy Holder: _____ Policy/SS#: _____

Group: _____

Employer of Insured: _____

Medicare Part B #: _____

Medicaid #: _____

Secondary Insurance: _____

Policy Holder: _____ Policy/SS#: _____

Medical History

Does your child have any seasonal or drug allergies? Yes No If yes, explain: _____

List any medications that your child takes, including eye drops and over the counter medications: _____

List all major injuries, surgeries, and/or hospitalizations, including any eye surgeries: _____

Note any of the following that your child currently has or has had:

Disease/Condition	Yes	No	Disease/Condition	Yes	No	Disease/Condition	Yes	No
Premature birth	<input type="checkbox"/>	<input type="checkbox"/>	Floaters	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>
Oxygen at birth	<input type="checkbox"/>	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Reading difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Low birth weight	<input type="checkbox"/>	<input type="checkbox"/>	Eye infection	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye/Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>
Slow development	<input type="checkbox"/>	<input type="checkbox"/>	Frequent styes	<input type="checkbox"/>	<input type="checkbox"/>	Flashes of light	<input type="checkbox"/>	<input type="checkbox"/>
Previous patching	<input type="checkbox"/>	<input type="checkbox"/>	Eye injury	<input type="checkbox"/>	<input type="checkbox"/>	Extreme nearsightedness	<input type="checkbox"/>	<input type="checkbox"/>
Turned or Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Is your child current on all his/her immunizations? Yes No

Which type of eye chart should be used for your child? Letters 'E' Chart Pictures

Does your child wear glasses? Yes No If yes, when are they worn? Full time Reading Computer Driving

Does your child wear contact lenses? Yes No If yes, what type? Rigid/Hard Soft Toric Extended wear

Disposable (brand _____ How often are they replaced? _____) Are his/her contacts comfortable? Yes No

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	Yes	No	Relationship	Disease/Condition	Yes	No	Relationship
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Crossed/ Lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____	Extreme nearsightedness	<input type="checkbox"/>	<input type="checkbox"/>	_____

Review of Systems

Do you currently, or have you had any problems in the following areas:

System	Yes	No	System	Yes	No
Constitutional (fever, weight loss/gain)	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal (arthritis, muscles, bones)	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Integumentary (skin, breast)	<input type="checkbox"/>	<input type="checkbox"/>
Ears, Nose, Mouth, Throat	<input type="checkbox"/>	<input type="checkbox"/>	Neurological (headaches, numbness)	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular/ Vascular (heart)	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric (mental, depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory (lungs)	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine (diabetes, thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal (stomach, intestines, liver)	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic/ Hematologic (blood, lymph node)	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary (kidneys, urinary/reproductive tract)	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/ Immunologic (allergies, immune)	<input type="checkbox"/>	<input type="checkbox"/>

Mark any of the following that you would like more information on:

- Contact lenses
- Disposable Contacts
- Contacts for dry eyes
- Contact lenses for astigmatism
- Lenses for skiing, scuba diving, biking, hunting, or sports
- Colored contacts
- Bifocal Contacts
- No line bifocals
- Special lens designs for computer users
- Laser Vision Correction
- Vision and reading problems of children
- Lazy eye
- Light weight glasses and thinner lenses

Payment for all medical services is the responsibility of the patient and is expected at the time of service.

I agree to pay all attorney fees, court costs, filing fees, including charges or commissions up to 50% that may be assessed to me by any collection agency retained to pursue this matter. I further agree to pay interest at the rate of one and one half percent per month (18% per year). I understand there is a \$15.00 service charge for all returned checks.

I hereby authorize the release of medical information concerning my illness and treatment by this clinic to my insurance company, and the Health Care Financing Administrations or its agents. I also authorize release of my personal medical information to any doctor to whom I may be referred for a consultation. I authorize payment of medical benefits to provider or facility. I understand that any other information about me including prescriptions for glasses or contact lenses, will not be released to anyone else without my written consent.

I hereby authorize any procedures, including dilation of the eyes, as may be deemed necessary for my care. I also grant permission for treatment if this patient is a minor.

Signature of patient or legal guardian

Today's Date

Reviewed by Dr. _____ Dates: _____

Review by Patient _____

Initial and date (subsequent visits)