Patient Information

Date:___/___/___

_____
First M Last

_____
Address

_____
City State Zip

_____ _____
Date of Birth Age Person responsible for payment

_____ _____
Home Phone Relationship to child

_____ _____
Cell Phone Grade

Responsible party's address if different from child:
_____
Address
_____
City State Zip

_____
Email Address

Would you like us to remind you of upcoming appointments via email? ❑ Yes ❑ No

Would you like to receive emails from us about upcoming events and other office news? ❑ Yes ❑ No

Medical Information

1. Who is your child's Pediatrician?_____
   Address: _____
   _____
   Phone: _____

2. How did you hear of us? _____

3. Did anyone refer you?_____

4. Date of last eye examination: _____

5. What is the primary reason for your visit today?
   _____
   _____
   _____

6. In what way does your child seem to be having visual difficulty?_____
   _____
   _____
   _____
   _____
   _____
   _____

7. How does your child complain about his/her vision?
   _____
   _____
   _____
   _____
   _____
   _____

8. Does your child wear glasses? ❑ Yes ❑ No
   How old are the glasses?_____

9. Does your child wear contact lenses? ❑ Yes ❑ No
   Soft / RGP / Hard (please circle one)

10. Please list **ALL** medications that your child is currently taking:
    _____
    _____
    _____

11. Please list any allergies your child has, including to medication and food: _____
    _____
    _____

`12. Does your child experience any of the following?

Blurred Vision	❑ Yes ❑ No
Color Vision Poor	❑ Yes ❑ No
Closing one eye?	❑ Yes ❑ No
Covering one eye?	❑ Yes ❑ No
Eyes frequently red?	❑ Yes ❑ No
Frequent styes?	❑ Yes ❑ No
Excessive eye rubbing?	❑ Yes ❑ No
Excessive blinking?	❑ Yes ❑ No
Tilting head when reading?	❑ Yes ❑ No
Bumping into objects?	❑ Yes ❑ No
Poor general coordination?	❑ Yes ❑ No
Light sensitivity?	❑ Yes ❑ No
Crossed/Turned Eyes?	❑ Yes ❑ No
Double Vision?	❑ Yes ❑ No
Frequent headaches?	❑ Yes ❑ No
Eyestrain?	❑ Yes ❑ No
Eyes hurt?	❑ Yes ❑ No
Eyes tearing?	❑ Yes ❑ No
Eyes tired?	❑ Yes ❑ No

13. Has your child had eye surgery? ❑ Yes ❑ No
    If yes, what kind of eye surgery?_____
    _____

14. Has your child had a concussion? ❑ Yes ❑ No
    If yes, when? _____

SCHOOL PERFORMANCE

Does your child like school? ❑ Yes ❑ No
Age at time of entrance for Kindergarten:_____
Has a grade been repeated? ❑ Yes ❑ No
Have there been any school difficulties? ❑ Yes ❑ No
If yes, please explain:_____
_____
_____
_____
_____
_____

Is school work (please circle): Average / Above Ave. / Below Ave.

Is there any subject(s) that seems particularly easy for your child?
_____
_____

Is there any subject(s) that seems particularly difficult for your child?
_____
_____

Does your child experience?

Loss of place while reading? ❑ Yes ❑ No
Poor comprehension? ❑ Yes ❑ No
Difficulty copying into notebook? ❑ Yes ❑ No
Letter reversals? ❑ Yes ❑ No
Number reversals? ❑ Yes ❑ No
Word reversals? ❑ Yes ❑ No
Poor handwriting? ❑ Yes ❑ No
Poor spelling? ❑ Yes ❑ No
Difficulty with math concepts? ❑ Yes ❑ No
Falling asleep while reading? ❑ Yes ❑ No
Use finger to keep place while reading? ❑ Yes ❑ No
Get close to book when reading? ❑ Yes ❑ No
Difficulty following directions? ❑ Yes ❑ No
Frequent daydreaming? ❑ Yes ❑ No
Omit words when reading? ❑ Yes ❑ No
Add words when reading? ❑ Yes ❑ No
Avoid reading? ❑ Yes ❑ No
Words run together when reading? ❑ Yes ❑ No

DEVELOPMENTAL HISTORY

Full term pregnancy? ❑ Yes ❑ No
Normal birth? ❑ Yes ❑ No
Any complications after birth? ❑ Yes ❑ No
Did your child crawl? ❑ Yes ❑ No
On all fours? ❑ Yes ❑ No
Age?_____
Age child first walked?_____
Age child spoke first words?_____
Age child spoke first sentences?_____
Was speech clear to others? ❑ Yes ❑ No
Was child active? ❑ Yes ❑ No
When fatigued, does child do any of the following?
(please circle) Sag / Become irritable / Become excited

When under stress, is there any pattern of behavior, such as thumb sucking, nail biting, etc?_____
_____
_____

Please list any serious illnesses or injuries:_____
_____
_____

Please list any surgeries:_____
_____
_____

Family Health History

Arthritis ❑ Yes ❑ No Who? _____
Cancer ❑ Yes ❑ No Who? _____
Cataract ❑ Yes ❑ No Who? _____
Diabetes ❑ Yes ❑ No Who? _____
Eye Tumors ❑ Yes ❑ No Who? _____
Glaucoma ❑ Yes ❑ No Who? _____
Heart Problems ❑ Yes ❑ No Who? _____
High Blood Pressure ❑ Yes ❑ No Who? _____
Macular Degeneration ❑ Yes ❑ No Who?_____
Retinal Disease ❑ Yes ❑ No Who? _____
Stroke ❑ Yes ❑ No Who? _____
Thyroid Disease ❑ Yes ❑ No Who? _____

Please read and sign.

1. **PAYMENT POLICY:** Full payment is expected at time of service.
2. **INSURANCE POLICY:** 100% of patient balance is required after insurance benefit is applied.
3. **AUTHORIZATION OF PAYMENT AND PATIENT RELEASE I authorize the direct payment of medical benefits to the physician and supplier for services rendered.**

I authorize the release of any medical or other information necessary to process this claim. I accept financial responsibility for any unpaid balance not covered by my insurance plan.

I HAVE READ AND UNDERSTAND STATEMENTS 1-3

Patient's Signature:_____ Guardian Signature:_____