

WELCOME TO OUR OFFICE

CHILD'S NAME _____ DATE _____
ADDRESS _____ APT _____ CITY _____ ZIP _____
PHONE DAY _____ EVENING _____ CELL _____
DATE OF BIRTH _____ AGE _____

SCHOOL _____ TEACHER _____ GRADE _____
HOBBIES OR ACTIVITIES _____

FATHER'S NAME _____ OCCUPATION _____ EMPLOYER _____
MOTHER'S NAME _____ OCCUPATION _____ EMPLOYER _____
BROTHERS and SISTERS (names and ages) _____

HOW WERE YOU REFERRED TO OUR OFFICE _____

MAIN REASON FOR TODAY'S VISIT _____
DATE OF LAST VISUAL EVALUATION _____ DOCTOR _____

NOTE ANY CONDITION YOU OR YOUR CHILD HAVE NOTICED

BLUR _____ HEADACHE _____ SQUINTING _____ POOR READING _____ HEAD CLOSE WHEN READING _____
SHORT ATTENTION SPAN _____ BELOW GRADE LEVEL _____ OTHER _____
DOES YOUR CHILD WEAR CONTACT LENSES? YES NO ARE YOU CONSIDERING CONTACT LENSES? YES NO

MEDICAL HISTORY

NAME OF MEDICAL DOCTOR _____ DATE OF LAST MEDICAL EXAM _____
HAS YOUR CHILD EVER BEEN TREATED FOR OR DIAGNOSED WITH: crossed eyes lazy eye color blindness
 glaucoma retinal disease cataracts eye injury macular degeneration eye infection premature birth asthma allergies
 neurological disorders head injury other? Please List _____

LIST MEDICATIONS YOUR CHILD IS TAKING _____

LIST ANY DRUG ALLERGIES _____

FAMILY HISTORY

Please list any parents, grandparents, siblings, aunts or uncles that have been diagnosed with the following conditions:
GLAUCOMA _____ CATARACTS _____
BLINDNESS _____ DIABETES _____
MACULAR DEGENERATION _____ HIGH BLOOD PRESSURE _____
CANCER _____ HEART DISEASE _____
OTHER _____

RESPONSIBLE PARTY INFORMATION

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____
RELATIONSHIP TO PATIENT _____ HOME PHONE _____
ADDRESS (if different from above) _____
DRIVERS LICENSE NUMBER _____ DATE OF BIRTH _____

I UNDERSTAND THAT ALL CHARGES ARE TO BE PAID AT THE TIME SERVICES ARE RENDERED OR PRIOR TO ORDERING MATERIALS. I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE.

SIGNATURE _____ DATE _____