WELCOME TO OUR OFFICE
Child Form

Patient Information

Last Name:_____

First Name:_____ MI:____

Age:_____Birth Date:_____ Gender: M F

Address:_____

City:_____State_____Zip:_____

Cell Phone:_____

Home Phone:_____

Email:_____

School:_____Grade:_____

Parent(s) Name(s):_____

Occupation(s):_____

Do you have vision coverage: ☐Yes ☐No

If yes, who?_____

How would you prefer to be contacted?

Text Cell Phone Email

Other:_____

Why do you feel your child needs a visual evaluation?

_____

_____

How long has this problem/difficulty been observed?

_____

Lifestyle Questions

Considering contacts for your child?

(Additional fees apply) ☐Yes ☐No

Does your child…? (Check all that apply)

☐…wear prescription glasses?

☐...have ultraviolet protection sunwear?

☐…participate in sports?

☐…have Transitions lenses (darken in the sun)?

☐…have "back up" prescription eyewear?

☐…wear contact lenses?

If so, what kind?_____

Solution Used:_____

☐…have a rapidly increasing prescription?

☐…have interest in a non-surgical vision correction?

How did you hear about our office?

If you are new to our office, please share with us how you found us.

☐Another Patient:Who?_____

☐Insurance List / Insurance Website

☐Internet: Which website?_____

☐Kids Directory

☐Radio

☐YP (Yellow Pages)

☐Other:_____

Patient Eye History

Date of Last Eye Exam:_____

Previous Eye Doctor:_____

Has your child ever experienced, been diagnosed, or been treated for any of the following?
(Check all that apply)

	Yes	No
Blurry Vision	☐	☐
Double Vision	☐	☐
Headaches	☐	☐
"Lazy Eye" / Amblyopia	☐	☐
Eye turn/Crossed Eye	☐	☐
Sensitivity to light	☐	☐
Difficulty Reading	☐	☐
Red Eyes	☐	☐
Floaters/Spots/Flashes	☐	☐
Pain/Irritation/Itch	☐	☐
Red Eye	☐	☐
Eye Injury/Trauma/Abrasion	☐	☐
Eye Fatigue/Tired Eyes	☐	☐
Color Blindness	☐	☐
Misreads words/letter reversals	☐	☐

Other eye problems:_____

_____

_____

Family Medical / Eye History

Have you or a family member been diagnosed with any of the following? (Please check all that apply)

	Child	Family Member?
Blindness	☐	☐
Cataracts	☐	☐
Epilepsy or Seizures	☐	☐
Glaucoma	☐	☐
Retinal Problems	☐	☐
Diabetes	☐	☐
Learning Disability	☐	☐
Eye Disease	☐	☐
Brain Tumor	☐	☐
Other?	☐	☐

The information in this confidential case history is critical to the evaluation.

Patient Medical History

Primary Physician:_____

Location:_____

Date of Last Physical Exam:_____

CURRENT MEDICATIONS: (List all medications including vitamins and supplements)

_____

_____

_____

Allergies to medication? ☐Yes ☐No

If so, what medications?_____

_____

Premature birth? ☐Yes ☐No

Any complications during pregnancy? ☐Yes ☐No

If yes above, please describe:_____

_____

Shown normal development? ☐Yes ☐No

Had physical/development therapy? ☐Yes ☐No

Have had any surgeries? ☐Yes ☐No

If so, please describe:_____

_____

List serious illnesses, bad falls, etc.:_____

_____

_____

_____

Has your child ever been diagnosed or treated for the following health problems? (Check all that apply)

☐Allergies	☐Blood/Lymph
☐High Blood Pressure	☐Immune System
☐Cholesterol	☐STD
☐Cardiovascular	☐Skin/Eczema/Rashes
☐Anemia	☐Arthritis
☐Headaches/Migraines	☐Muscle/Bone
☐Diabetes	☐Neurological
☐Endocrine	☐Psychiatric
☐Digestive	☐Asthma
☐Kidney	☐Respiratory
☐Reproductive	☐Cancer

Other Health Problems:_____

_____

_____

_____

Education History

Has your child had extra help or tutoring in school?

_____

_____

Has a grade been repeated? ☐Yes ☐No

If so, which?_____

How would you describe your child's reading ability?

_____

Does he/she like to read for fun?_____

School/after-school activities your child is involved in:

_____

How much screen time does your child get per day?

_____

Do you feel your child is achieving up to potential?

_____

Privacy Practices for Health Information

NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of Pierce Vision Specialists' statement on privacy practices.

AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Pierce Vision Specialists to release any medical or incidental information that may be necessary for medical benefit or to obtain payment for services. This includes but is not limited to vision plans or medical insurances.

CONSENT FOR TREATMENT: I/We hereby authorize Pierce Vision Specialists to administer diagnostic and medical procedures as may be necessary for proper health care.

FINANCIAL POLICY: I/We understand that charges incurred are ultimately the patient's responsibility. Past due accounts may be turned over to an outside collection agency.

SCHOOL RELEASE: I/We authorize the release of records or reports to my child's school <u>if requested</u> and understand that additional service fees may apply.

_____ _____

Parent/Guardian Signature Date

OPTOMAP

We can now offer state-of-the-art technology to view the inside of your eye – *The optomap!* Our doctors recommend the optomap procedure for children, as well as adults, because many vision problems begin at an early age. These images can be saved as a baseline for future exams.

There is an additional fee of only $35 for this procedure (covers both eyes).

☐Yes, I consent to this doctor recommended procedure as part of my child's comprehensive exam.

☐No, I do not consent to this procedure at this time.

_____

Parent/Guardian Signature