



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	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
"Lazy Eye" / Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>
Eye turn/Crossed Eye	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to light	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Reading	<input type="checkbox"/>	<input type="checkbox"/>
Red Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Floaters/Spots/Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Pain/Irritation/Itch	<input type="checkbox"/>	<input type="checkbox"/>
Red Eye	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury/Trauma/Abrasion	<input type="checkbox"/>	<input type="checkbox"/>
Eye Fatigue/Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Color Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Misreads words/letter reversals	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>
Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>
Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Other?	<input type="checkbox"/>	<input type="checkbox"/>

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

Patient Medical History	Education History																							
Primary Physician: _____ Location: _____ Date of Last Physical Exam: _____ CURRENT MEDICATIONS: (List all medications including vitamins and supplements) _____ _____ Allergies to medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what medications? _____ _____ Premature birth? <input type="checkbox"/> Yes <input type="checkbox"/> No Any complications during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes above, please describe: _____ _____ Shown normal development? <input type="checkbox"/> Yes <input type="checkbox"/> No Had physical/development therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Have had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> 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) <table style="width:100%; margin-top: 10px;"> <tr> <td><input type="checkbox"/>Allergies</td> <td><input type="checkbox"/>Blood/Lymph</td> </tr> <tr> <td><input type="checkbox"/>High Blood Pressure</td> <td><input type="checkbox"/>Immune System</td> </tr> <tr> <td><input type="checkbox"/>Cholesterol</td> <td><input type="checkbox"/>STD</td> </tr> <tr> <td><input type="checkbox"/>Cardiovascular</td> <td><input type="checkbox"/>Skin/Eczema/Rashes</td> </tr> <tr> <td><input type="checkbox"/>Anemia</td> <td><input type="checkbox"/>Arthritis</td> </tr> <tr> <td><input type="checkbox"/>Headaches/Migraines</td> <td><input type="checkbox"/>Muscle/Bone</td> </tr> <tr> <td><input type="checkbox"/>Diabetes</td> <td><input type="checkbox"/>Neurological</td> </tr> <tr> <td><input type="checkbox"/>Endocrine</td> <td><input type="checkbox"/>Psychiatric</td> </tr> <tr> <td><input type="checkbox"/>Digestive</td> <td><input type="checkbox"/>Asthma</td> </tr> <tr> <td><input type="checkbox"/>Kidney</td> <td><input type="checkbox"/>Respiratory</td> </tr> <tr> <td><input type="checkbox"/>Reproductive</td> <td><input type="checkbox"/>Cancer</td> </tr> </table> Other Health Problems: _____ _____ _____ _____	<input type="checkbox"/> Allergies	<input type="checkbox"/> Blood/Lymph	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Immune System	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> STD	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Skin/Eczema/Rashes	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Muscle/Bone	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Neurological	<input type="checkbox"/> Endocrine	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Digestive	<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Reproductive	<input type="checkbox"/> Cancer	Has your child had extra help or tutoring in school? _____ _____ Has a grade been repeated? <input type="checkbox"/> Yes <input type="checkbox"/> 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? _____ _____ <table style="width:100%; background-color: #e0e0e0; text-align: center; font-weight: bold;"> <tr> <td style="padding: 2px;">Privacy Practices for Health Information</td> </tr> </table> 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 _____	Privacy Practices for Health Information
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OPTOMAP																								
We can now offer state-of-the-art technology to view the inside of your eye – <i>The optomap!</i> 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). <input type="checkbox"/> Yes, I consent to this doctor recommended procedure as part of my child's comprehensive exam. <input type="checkbox"/> No, I do not consent to this procedure at this time. _____ Parent/Guardian Signature																								