Eagleville EYE CLINIC

WELCOME TO OUR OFFICE Child Form

Patient Information

Today's Date: ____________________

Last Name: ____________________

First Name: ____________________ MI: ____

Nickname: ____________________

Address: ____________________

City: ____________ State: ______ Zip: ______

Home Phone: ____________________

Contact Cell Phone: ____________________

Gender: M F Date of Birth: __________ Age: ______

School: ____________________ Grade: ______

Parent/Guardian Name: ____________________

Occupation: ____________________

Parent/Guardian Name: ____________________

Occupation: ____________________

Parent Email: ____________________

Name of person responsible for this account: ____________________

Relationship to patient: ____________________

Phone: (if different from above)____________________

Why do you feel your child needs a visual evaluation?

____

____

____

How long has this problem/difficulty been observed?

____

How did you find out about our office?

Where have you seen us? *(Check all that apply.)*

- ❑ Website/Internet
- ❑ Drive by
- ❑ Social Media
- ❑ Friend/Family:____________________
- ❑ Other: ____________________
- ❑ Insurance List
- ❑ Advertisement

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.)

	Currently	In the Past
Blurry Vision	❑	❑
Double Vision	❑	❑
Headaches	❑	❑
Floaters/ Spots/flashes	❑	❑
Color Blindness	❑	❑
Sensitivity to light	❑	❑
Difficulty reading	❑	❑
Misreads words/letter reversals	❑	❑
Eye Fatigue/ Tired Eyes	❑	❑
Pain/ Irritation/Itch	❑	❑
Red Eyes	❑	❑
"Lazy Eye"/ Amblyopia	❑	❑
Eye turn/Crossed eye	❑	❑
Eye Injury/ Trauma/ Abrasion	❑	❑
Allergy	❑	❑

Other eye problems: ____________________

____

Lifestyle Questions

Are you considering contacts for your child?

❑ Yes ❑ No ❑ Maybe

Does your child…? (Check all that apply)

❑… wear prescription glasses?

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

❑… have "back up" prescription eyewear?

❑… wear contact lenses?

If so, what type? (circle)

Daily wear Disposable Monthly replacement

❑…Play sports? Please list:____________________

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?
Lazy Eye	❑	❑ ____________
Cataracts	❑	❑ ____________
Glaucoma	❑	❑ ____________
Eye Turn/Crossed eyes	❑	❑ ____________
Retinal Problems	❑	❑ ____________

Other? ____________________

Please turn over. Thank you.

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

Patient Medical History

Primary Physician: ____________________

Location: ____________________

Date of Last Physical Exam: ____________________

CURRENT MEDICATIONS (Rx or Over-the-Counter):
(*List all medications including eye drops, vitamins, etc.*)

____

____

Allergies to medications? ❑ Yes ❑ No
If so, what medications? ____________________

____

Premature birth? ❑ Yes ❑ No
Any complications during pregnancy? ❑ Yes ❑ No
If yes above, please describe: ____________________

____

Has your child…
Shown normal development? ❑ Yes ❑ No
Had physical/developmental therapy? ❑ Yes ❑ No
Been treated for Lazy Eye? ❑ Yes ❑ No
Had any surgeries? ❑ Yes ❑ No

If so, please describe: ____________________

____

____

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	❑ Acne
❑ Cardiovascular	❑ Skin/ Eczema/ Rashes
❑ Anemia	❑ Diabetes
❑ Headaches/Migraines	❑ Arthritis
❑ Sinus Problems	❑ Muscle/Bone disorder
❑ Endocrine	❑ Neurological
❑ Digestive	❑ Psychiatric
❑ Kidney	❑ Asthma
❑ Respiratory	
❑ Genitourinary	❑ Cancer
❑ ADD/ADHD	❑ Epilepsy/Seizures

Other: ____________________

____

Education/Social History

How does your child perform in school? (circle)
Above grade level   At grade level   Below grade level

Does your child like to read?

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

____

Does your child play video or computer games?

Privacy Practices for Health Information

The Eagleville Eye Clinic has established a *Privacy Policy* & guidelines for *Privacy Practices* within this office. A copy of these policies can be provided to you at your request.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dr. Rena Cron/the Eagleville Eye Clinic 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 hereby authorize the Eagleville Eye Clinic to administer diagnostic and medical procedures as may be necessary for proper health care.

____________________   ____________
Parent/ Guardian Signature   Date

Payment Agreement/Insurance Authorization

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How will payment be made for today's visit? (circle)
Cash   Check   Credit Card   Care Credit   Insurance

We will gladly file your insurance for today's visit.
****However, we cannot guarantee payment**.

I understand that if insurance is filed for vision or medical services, all payments will be assigned directly to Dr. Rena Cron. I understand that I am financially responsible for all charges whether or not paid by insurance, including all collection costs and legal fees for unpaid balances.

____
Parent/ Guardian Signature