# MEDICAL INFORMATION

**FAMILY HISTORY** (BIOLOGICAL_______ / ADOPTED _______ )

*LIST BELOW BROTHERS AND SISTERS OF PATIENT:*

| NAME | AGE | GLASSES? | DESCRIBE DISEASE OR ABNORMAL EYE CONDITION |
|---|---|---|---|
| | | | |
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| | | | |
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*LIST BELOW (BLOOD RELATIVE) FATHER, MOTHER, GRANDPARENTS, UNCLES, AUNTS AND COUSINS WHO HAVE A HISTORY OF SERIOUS DISEASE OR MISALIGNED EYES (STRABISMUS):*

| RELATIONSHIP | GLASSES? | DESCRIBE DISEASE OR ABNORMAL EYE CONDITION |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

DO ANY DISEASES RUN IN THE FAMILY?............ ☐ YES ☐ NO

*(ESPECIALLY NOTE CROSSED EYES, AMBLYOPIA (LAZY EYE), BIRTH DEFECTS, NEUROLOGICAL DISEASE?)*

IF SO WHAT?_______________

**BIRTH HISTORY**

WAS THE BABY PREMATURE? ☐ YES ☐ NO HOW MANY WEEKS?_______________ BIRTH WEIGHT_______________

WAS THERE ANY TROUBLE WITH DELIVERY?............ ☐ YES ☐ NO

WAS THERE ANY BREATHING OR FEEDING PROBLEM IN THE FIRST WEEK OR SO?............ ☐ YES ☐ NO

WAS THERE ANY TROUBLE OR DELAYED SITTING, WALKING, TALKING OR DEVELOPMENT?............ ☐ YES ☐ NO

ARE THERE ANY **OUTSTANDING** SCHOOL DIFFICULTIES?............ ☐ YES ☐ NO

**MEDICAL HISTORY**

HAS THE CHILD'S REGULAR DOCTOR SUSPECTED OR DIAGNOSED ANY SERIOUS ILLNESS?............ ☐ YES ☐ NO

IF SO, WHAT?_______________

DOES THE CHILD TAKE MEDICATIONS OR TREATMENTS FREQUENTLY OR REGULARLY?............ ☐ YES ☐ NO

IF SO, WHAT?_______________

IS HE/SHE KNOWN TO BE ALLERGIC TO ANY MEDICATION? (SUCH AS ANTIBIOTICS, IODINE, TAPE)............ ☐ YES ☐ NO

IS HE/SHE KNOWN TO BE ALLERGIC TO ANY ENVIRONMENT?............ ☐ YES ☐ NO

**EYE HISTORY**

HAS THE CHILD EVER HAD EYE CARE BEFORE?............ ☐ YES ☐ NO

BY?_______________ WHAT CITY?_______________ DATE OF LAST EYE EXAM?_______________

ARE GLASSES WORN?............ ☐ YES ☐ NO

AGE FIRST WORN?_______________

HAS HE/SHE EVER HAD AN EYE INJURY?............ ☐ YES ☐ NO

HAS HE/SHE EVER HAD AN EYE OPERATION?............ ☐ YES ☐ NO

**REASON FOR VISIT:**

_______________

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I authorize use of this form on all my insurance submissions and release of information to all my insurance companies. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies and to have payments made directly to my doctor. A copy of this authorization may be used in place of the original. This information is accurate and true to the best of my knowledge. I understand that I am responsible for paying for services rendered, and interest charges of 1 1/2 percent per month shall accrue on payments not made within 60 days. In the event payment is not made and the account is referred to a collection agency or attorney, I will pay the costs of collection including attorney's fees and costs incurred. A fee of $25.00 will be charged on all checks returned for insufficient funds.

Signature_______________ Date_______________

## PATIENT INFORMATION

________________ PAYMENT FOR SERVICES EXPECTED AT THE TIME OF OFFICE VISIT

DATE:____________________

CHILD'S NAME________________________________________________________
LAST FIRST MIDDLE

AGE:____________________ BIRTH DATE(____/____/____)____________________

SEX:____________ HAS ANYONE ELSE IN THE FAMILY BEEN A PATIENT?____________________

RESPONSIBLE PARTY: ______________________________ RELATIONSHIP:____________

STREET ADDRESS:________________________________________________________

CITY, STATE, ZIP________________________________________________________

HOME PHONE:______________ PARENT'S DRIVER'S LICENSE #:______________ PARENT'S SOCIAL SECURITY #______________

REFERRED BY:________________________________________________________

PATIENT'S M.D.______________________________ SCHOOL:______________________

FATHER'S EMPLOYER:______________________________ PHONE:______________

MOTHER'S EMPLOYER:______________________________ PHONE:______________

INSURANCE______________________________ IF WE ARE A PROVIDER FOR YOUR HMO OR PPO, PLEASE SHOW US YOUR CARD.

NAME OF INSURED:______________ DATE OF BIRTH OF INSURED______________ ID# ______________

MEDICAID: ☐ YES PLEASE SHOW US PATIENT'S CARD ☐ NO

PARENT(S): MARRIED__________ SEPARATED__________ DIVORCED__________ WIDOWED__________ SINGLE__________

NEAREST LOCAL RELATIVE OR FRIEND:______________________________ PHONE:______________

**PLEASE COMPLETE THE OTHER SIDE OF THIS FORM.**

**DO NOT WRITE BELOW THIS LINE**

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DIAGNOSIS:

SURGERY: