

Eagle Glen Optometry

Children's Information Sheet

Name: _____ Nick Name: _____ Sex: M F
Last First M.I.

Birth date: ____/____/____ Age: _____ Grade: _____ Last Eye Exam: _____

School: _____ Pediatrician: _____

Person Responsible for Account

Name: _____ Birth date: ____/____/____ SSN: ____ - ____ - ____
Title Last First M.I.

Address: _____ Phone (Hm): _____
Street City Zip

Employer: _____ Phone (Wk): _____

Relationship to Patient: _____ Vision Insurance: _____ Member's ID#: _____

Health Insurance: _____ Member's ID #: _____

How did you hear of us? Referred by: _____ / Yellow Pages / Recall Card / Mailers / Insurance List / Location Only

I, the undersigned, certify that my dependent or I have insurance with the company listed above and assign all benefits directly to the Doctor. **I understand that I am financially responsible for all charges.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____

Relationship _____

Date ____/____/____

Reason(s) for today's visit? _____

Allergies: _____ Current Medications: _____

Personal & Family History: (Check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Amblyopia (lazy eye) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nearsightedness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Premature Birth (# weeks) _____ |
| <input type="checkbox"/> Astigmatism | <input type="checkbox"/> Juvenile Rheumatoid Arthritis | |
| <input type="checkbox"/> Crossed Eyes (Strabismus) | <input type="checkbox"/> Migraines | |

Is there a history of eye surgery, eye injury, or serious eye infection? (*Describe*) _____

Vision & Learning Questions (*parent and child to answer questions together*)

Do headaches occur at the end of the school day or during reading periods? Yes No

Is it hard for you to see what the teacher is writing on the board? Yes No

When you read is it hard to focus on the words of a page? Yes No

When you read do you lose your place often and feel you need to use a guide (finger)? Yes No

Do you have any other eye concerns not addressed in the above? (*Please explain*) _____