NEW PATIENT INFORMATION

PATIENT NAME _____NICK NAME _____AGE_____
LAST FIRST MIDDLE
DATE OF BIRTH ____/_____/____ SEX: M or F (CIRCLE ONE) HOME PHONE (____)_____

HOME ADDRESS _____
STREET APT# CITY STATE ZIP

NOTE: THE PARTY RESPONSIBLE FOR ALL FEES FOR SERVICES IS THE PARENT OR GUARDIAN WHO ACCOMPANIES A CHILD FOR TREATMENT. WE CANNOT BILL A THIRD PARTY FOR THESE SERVICES.

NAME RESPONSIBLE PARTY: _____ RELATIONSHIP TO PATIENT _____
ADDRESS _____ PHONE (____)_____
STREET APT# CITY STATE ZIP
SSN OF RESPONSIBLE PARTY _____

PARENT #1 INFO Name _____
OCCUPATION _____ WORK PHONE(_____)_____

PARENT #2 INFO Name _____
OCCUPATION _____ WORK PHONE(_____)_____

PEDIATRICIAN NAME/LOCATION OF OFFICE _____

DO YOU WANT A REPORT SENT TO YOUR PEDIATRICIAN WITH RESULTS OF THIS OR FUTURE VISITS? YES or NO

REFERRED BY _____

REASON FOR TODAY'S EXAM _____

LIST ALL ALLERGIES ( ) DUST ( ) POLLEN ( ) FOOD OTHER:_____
DRUG SENSITIVITY OR ALLERGY (DRUG NAME AND REACTION)_____

CURRENT MEDICATIONS (PRESCRIPTION AND NON-PRESCRIPTION) INCLUDE INHALERS, TOPICAL CREAMS AND EYE DROPS_____
RECENT OR MAJOR ILLNESSES _____
HOSPITALIZATIONS, IF ANY, WITH DATES _____
PREVIOUS EYE PROBLEMS, EYE TREATMENT AND DATES _____
WHEN WAS LAST EYE EXAM OR SCREENING_____
WERE EYE GLASSES PRESCRIBED, IF SO WHEN _____

Check all that applies to PATIENT?

Crossed eye ____	Tearing, mucus ____	Sees spots ____
Wandering eye _____	Itching, burning ____	Holds things close ____
Sensitive to light _____	Decreased vision ____	Learning problems ____
Pain in eye _____	other _____	

DEVELOPMENT ( ) SLOW ( ) AVERAGE ( ) ABOVE AVERAGE BIRTH WEIGHT _____
CURRENT GRADE IN SCHOOL _____ AGES OF SIBLINGS _____
NAMES OF OTHER FAMILY MEMBERS WHO ARE PATIENTS HERE _____
PAST MEDICAL PROBLEMS:
Complications during pregnancy_____ Birth abnormalities _____
Blood defect/bleeding tendency _____ Kidney problems _____
Other _____

FAMILY HISTORY: PLEASE INDICATE WHO IN THE FAMILY HAS HAD THE FOLLOWING CONDITIONS (FOR EXAMPLE: MOTHER, FATHER, SIBLING, GRANDPARENT, AUNT, UNCLE)

Learning disability _____	Glaucoma _____	Farsighted (trouble seeing NEAR) _____
Crossed eyes _____	Blindness _____	Nearsighted (trouble seeing FAR) _____
Wandering eye _____	Detached retina_____	Astigmatism _____
Lazy eye _____	Color blindness _____	Eye surgery _____
Cataracts _____	Diabetes _____	