PLEASE PRINT (CHILD'S INFORMATION) Date: _____/_____/_____

Name: _____ Birthday: _____/_____/_____

Address: _____

City, State, Zip: _____

Parent Name: _____

Cell Phone #: _____ School_____

Email:_____ Contact Preference: E-Mail? Text? Call?

Insurance Provider: _____ Insured Party's SS#: (Last 4 Digits only)_____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

VISUAL HISTORY

Date of Last Eye Exam: _____ Location / Doctor: _____

Are you interested in contact lenses or myopia control?_____

Reason for today's Exam: Contacts_____Glasses_____Annual exam_____

Describe any problems your child is experiencing: _____

_____

_____

How many hours per day does your child use a computer? _____

Hobbies/Sports/Interests:_____

CURRENT CONTACT LENS WEARERS:

What type of contacts are you currently wearing? _____

How often do you change your contacts? _____

What type of cleaning solutions do you currently use? _____

Do your 'backup' glasses have an updated prescription ? Y☐ N☐

MEDICAL HISTORY

Who is your child's medical doctor?_____(Location)_____

YES	NO	Does patient OR any family members have:	
☐	☐	Diabetes?	Who?_____
		What was the last blood sugar reading?_____	
		Is patient on an insulin pump? _____	
☐	☐	Cataracts?	Who?_____
☐	☐	Glaucoma?	Who?_____
☐	☐	Macular Degeneration?	Who?_____
☐	☐	Lazy Eye?	Who?_____

Does the patient presently experience any of the following:

☐	☐ Headaches?
☐	☐ Double Vision?
☐	☐ Eye pain?
☐	☐ Blurred Vision?

Is there patient history or family history of any eye injuries, surgeries, or diseases?

Please Describe _____

Any other medical conditions: _____

Current Medications/EyeDrops: _____

Allergies: _____

How can we improve our care/team/office to better serve your needs?