SUBURBAN EYE CARE, P.C.

Name_____ **Date of Birth**_____

Has your child ever worn glasses? ❑ Yes ❑ No Does he/she wear glasses now? ❑ Yes ❑ No
If yes: ❑ for distance only ❑ for near only ❑ wears them full time

Has your child ever had Vision Therapy? θ Yes θ No

Does child wear contact lenses? ❑ Yes ❑No Interested in trying contact lenses? θ Yes θ No

HEALTH HISTORY: Check any conditions that apply to your child or that run in your family.

Lazy eye	θ Child	θ Family
Turned eye	θ Child	θ Family
Color Blind	θ Child	θ Family
Light sensitive	θ Child	θ Family
Cataracts		θ Family
Glaucoma		θ Family
Macular Degeneration		θ Family

MEDICATIONS:
_____
_____

DRUG ALLERGIES:
_____
_____

Suburban Eyecare can now electronically view medication history for our patients.
Disclaimer: Certain information may not be available or accurate in this report, including items that the patient has asked to not be disclosed due to privacy concerns, we will also verify medication history independently with the patient.
Consent to view their medication history: θYes θNo

Has your child had any eye surgeries? If so, when, which eye and type of procedure:_____

_____

How do you feel your child is doing in school? θ Well θ Below potential θ Poorly

- θ Does your child squint when looking up from reading?
- θ Have trouble seeing the chalkboard?
- θ Frequently blink or rub eyes?
- θ Have headaches after doing school work?
- θ Frequently awkward, bumps into things or knock things over?
- θ Have trouble copying work from the chalkboard to paper?
- θ Spends a long time doing homework that should take only a few minutes?
- θ Frequently loses place when reading or skips or re-reads words and lines?
- θ Reverses words or letters (was for saw, b for d) beyond second grade?
- θ Gets tired quickly when doing reading or homework?
- θ Daydreams a lot? Stares off into the distance frequently?
- θ Learns best through auditory tactics (listens to learn)?
- θ Avoids work that includes reading?
- θ Is more than 1 year behind group in reading-related skills?

FOR FUN! What activities does your child participate in?

_____

Any special or protective eyewear for your sport? θ Yes θ No

Does your child watch television? θ Yes θ No Number of hours daily_____

Does your child use a computer at home/school? θ Yes θ No Number of hours daily_____

Does child play video games? θ Yes θ No Number of hours daily_____

SUBURBAN EYE CARE, P.C.

Childs Name: _____ Date of Birth: _____

Parents/Guardian Names:

_____Birth Date: _____

_____Birth Date: _____

Address_____

City_____ State _____ ZIP_____

Home Phone _____Cell Phone_____

Email _____

Race_____ Are you Hispanic? Yes No

Birth State_____ Mothers Maiden Name_____

NEW PATIENTS: WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?
Name of friend or relative:
_____
If not referred, how did you choose our office for your visual needs?

θ Saw the office θ Internet Search θ Ad in publication θ Insurance θ Doctor Talk/ Workshop

FINANCIAL AUTHORIZATION:

I authorize and request my insurance company to pay directly to Suburban Eye Care, P.C.
I understand that my insurance carrier may pay less than the billed services and materials. I agree to be responsible for the payment of all services and materials rendered on my behalf or my dependents. Any portion not paid by the insurance company will be the patient's responsibility. A 1 ½% finance charge will be applied to any amount over 30 days.

X_____ _____
Patient/ Guardian Signature Date

HIPAA PRIVACY POLICY:

I have received OR was offered and declined a notice of Suburban Eye Care, P.C. privacy laws HIPAA.

X_____ _____
Patient/ Guardian Signature Date