



Our objective is to provide you the best of vision care. To do this it is necessary that we know everything we can about your eyes. This includes your seeing needs and present health condition. Please answer all questions about your vision. What may seem a silly answer to you might be the very thing that will make your problem clearer to us so we can help you to attain eye comfort and visual efficiency.

Name: _____ DOB: _____
Address: _____ Zip: _____
City, State: _____ Occupation: _____
Primary Phone: _____ Secondary Phone: _____
Spouse's Name: _____ Phone: _____
Spouse/Parents Employer: _____ Phone: _____
Parent's Name (if a minor): _____ Phone: _____
If in school, what grade/level? _____

How did you hear about us?:

Website Insurance Yellow/ GTE Superpages Other

If referred by a person (or other source), whom may we thank?

Insurance Information (please fill out completely)

We provide the service of billing your insurance company for you. Your co-payment (the portion of your bill that is not covered by insurance) is expected to be paid in full on the date of service.

Name of Primary Insured: _____
Primary's Date of Birth: _____ Primary's Last 4 Digits of SSN: _____
Insurance Company: _____ Phone: _____
Address: _____
City, State, Zip: _____
ID #: _____ Group #: _____

I authorize payment of benefits to my physician. I agree to be personally responsible for payment of all services rendered not covered by my insurance company. Also, by signing below, you acknowledge receiving our Notice of Privacy Practices.

Signature: _____ Date: _____

Most Recent Eye Exam:
 Date: _____
 Doctor: _____
 Optometrist
 Eye Surgeon (Ophthalmologist)

Do your parents/grandparents have any of the following:

Yes	No	
		Macular Degeneration?
		Glaucoma?
		Diabetes?

Do you have, or have you ever had, any of the following:

Yes	No	
		Heart Problems?
		High Blood Pressure?
		Diabetes?
		Thyroid Problems?
		Head or Eye Trauma?
		Glaucoma?
		Double Vision?
		Cataracts?
		Retinal Detachments?
		School Achievement Problems?

For What Purpose is Today's Visit:

Yes	No	
		Is this a periodic checkup?
		A medical issue?

Are you interested in:

		Contact Lenses?
		Glasses or Sunglasses?
		Vision Therapy?

Other Information—Have you ever had:

		Your eyes dilated?
		Any type of refractive surgery?

Are you taking any medications? If yes, please list: _____

Please list any medications to which you are allergic: _____

What type of sports/activities do you do? _____

Are you satisfied with your current pair of glasses? (circle) Y / N

If not, what would you change about them? _____

How many hours are you on the computer each day? _____

Do you wear contacts (circle)? Yes / No Soft / Hard

How often do you change out your disposable lenses? _____

Do you sleep in your contacts? Y / N

What lens cleaning solution do you use? _____

How would you prefer to be contacted for future visits?

Text message---Cell phone number: _____

Via email---Current email: _____

Developmental History

Is the child adopted? _____ If yes, does the child know? _____ Age when adopted _____
 Full term pregnancy? _____ Normal birth? _____
 Any complication before, during or following delivery? _____
 Was the child exposed in utero to: drugs alcohol nicotine
 Did your child crawl? Yes No Age _____ Age at which child walked? _____
 Age of speech: First word? _____ Sentences? _____
 When fatigued, child will: Sag _____ Become irritable _____ Excited _____
 Under tension, is there any pattern of behavior, thumb-sucking, etc. _____

School

Age at time of entrance? _____ Kindergarten _____ First grade _____
 Does child like school? _____ Was a grade repeated? _____ Which one? _____
 Is school work? average better than average below average
 Have there been any school difficulties? _____
 What subjects are considered easiest? _____ Most difficult? _____
 Does your child like to read? Yes No _____
 Does your child regularly have school homework? Yes No
 Average amount of time spent on homework each night: _____
 How does your child deal with homework? little to no resistance very resistant
 Does test taking appear to cause anxiety? Yes No _____
 Has your child ever been retained from recess or after school? Yes No
 How did your child react to retention? _____
 Does the school consider your child to have a learning problem? Yes No _____

 Does the school consider your child to have a discipline problem? yes No _____

Visual History

Previous visual examinations:
 Reason for examination Doctor's Name Date Result

Members of family who have had visual attention and why:

Give a brief description of your child as a person:

_____ Initial _____ Date