



WELCOME TO OUR OFFICE

Child's name _____	Date of birth _____	Age _____
Address _____	Date of last exam _____	Sex _____
City _____ State _____ Zip _____	Vision insurance _____	
Phone number _____	School _____	Grade _____
Parent's/guardian's name _____	Teacher's name _____	
Parent's Driver's License No. _____	Parent's Employer _____	
Parent's Social Security No. _____		
Emergency Contact: _____	Phone: _____	

What is the purpose of your visit today? _____

Child's free-time activities _____

How will you settle your account today? Check Cash Credit card

How did you hear about our office?	Has your child ever had any:
<input type="checkbox"/> Friend or relative. Who? _____	Eye injuries _____
<input type="checkbox"/> Another doctor. Who? _____	Eye infections _____
<input type="checkbox"/> Yellow pages. Which one? _____	Eye surgery _____
<input type="checkbox"/> Radio announcement. Which station? _____	Vision therapy _____
<input type="checkbox"/> Vision care plan	Allergies: _____
<input type="checkbox"/> Other _____	Child's current medications (list): _____

Diagnostic Issues

Please list any problems with your child's vision, or problems with wearing glasses or contact lenses:

Y N Has your child ever worn glasses?

Y N Does your child have more than one pair of current glasses?

Y N Do you feel that your child is achieving at his or her potential in school?

Y N Is your child at risk of an eye injury because of participation in sports?

Y N Does your child have trouble with reading in school?

Y N Is your child interested in wearing contact lenses?

Y N Is there anyone in your family that has not had their eyes checked in the last three years?

Signature _____ Date: _____