CHILDREN'S DATA FORM

NAME OF PATIENT:______________________________
ADDRESS:______________________________
DATE OF BIRTH:______________ HOME PHONE #:______________
SCHOOL:______________ GRADE:________

NAME OF MOTHER:______________ SOCIAL SECURITY #______________
ADDRESS:______________ HOME PHONE #______________
CELL PHONE #______________
EMPLOYER:______________ WORK PHONE #______________

NAME OF FATHER:______________ EMPLOYER:______________
WORK PHONE #:______________ SOCIAL SECURITY#:______________
ADDRESS:______________ HOME PHONE #______________
CELL PHONE #:______________

List siblings and ages:______________________________
____
How is the child doing in school? ______________________________
____
Has the child had any special testing in school?______________
If so, when and what type?______________
Does child live with both parents?______________
If not, with whom does the child live?______________
Who referred you to our office and why?______________
Describe any visual symptoms or problems:______________
____
When was your child's last eye examination?________Where was this done?__________
How much time does child spend using a computer?______________
Do your child's eyes get tired from doing close work?______________
What hobbies/sports does he/she enjoy?______________
Who is his/her physician?____________When was his/her last visit?____________ List any medications he/she is taking and why:______________
____
Please list any unusal medical history.______________
To what medications is he/she allergic?______________
Any other allergies?______________
Is there a family history of diabetes?______Hypertension?______Glaucoma?____
Insurance Carrier:______________Policy ID #:______________

Office Policy: It is expected that fees are paid at the time of service. We accept cash, checks, Visa, and Mastercard. Deposits are required for any lab work at the time of the order. Accounts not paid in a timely manner will be subject to a monthly (1.5%) finance charge. If accounts need to be sent to collection, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 29% of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts. Insurance forms will be filed when possible, but the parent or guardian is responsible for payment of all fees. Patients with managed-care plans are totally responsible for their copayments and services NOT covered by their plans.

Signature of Parent or legal guardian:______________________ Date:______________