YOUTH REGISTRATION AND MEDICAL HISTORY

We require payment in full and/or insurance copays at the time services are rendered or when eyewear is ordered. Insurance is billed as a courtesy to our patients. We accept cash, checks, Visa, Mastercard, Discover, and Care Credit.

Date:	Birth date:	Email:

Last name:	First:	Middle:

Mailing Address:	City/State/Zip:

Gender: ☐M ☐F	Home Phone:

Emergency Contact Person Name & Phone: *(other than custodial parent)*	

If your child is a student, school:

Major Reason for Eye Exam:

Please state any learning difficulties:

Child's Physician & Location:

List any medications the child are currently taking (prescription and/or over-the-counter):

List any medication or eye drops you are allergic to:

General Health:	Health History:	Concerns:	School Performance:
Has the child ever had or currently have:	Does/did anyone in the child's **<u>immediate</u>** family have/had:	☐ Problem Pregnancy	If the child is in school:
☐ Allergies	☐ Diabetes	☐ Birth Defect	☐ Likes School
☐ Arthritis	☐ Glaucoma	**Does the Child complain of:**	☐ Working @ grade level
☐ Diabetes	☐ Blindness	☐ Headache	☐ Are you satisfied w/your child's performance in school?
☐ Cancer	☐ Cataracts	☐ Blurred vision @ distance	☐ Has a grade been repeated?
☐ Headaches	☐ Crossed Eyes	☐ Blurred Vision w/reading	☐ Is your child being tutored?
☐ Thyroid Disease	☐ Lazy Eye	☐ Tired or Sore Eyes	☐ Short attention span?
☐ Kidney Disease	☐ Macular Degeneration	☐ Double Vision	
☐ Drug Reaction	☐ Hyperthyroidism	☐ Poor Coordination	☐ Would you like a written vision report sent to the teacher?
☐ High Blood Pressure	☐ Cancer		Please initial:_____
☐ High Cholesterol	☐ Hypertension	**Child's Interests:**	☐ May we have permission to dilate your child's eyes if recommended?
☐ Eye Surgery	☐ Hypothyroidism	☐ Reading	Please initial:_____
☐ Itchy Eyes		☐ Computer	
☐ Pain		☐ Video Games	
☐ Eye Disease		☐ Team Sports	
☐ Other		☐ Music	
☐ None of the Above			

I understand that all copays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

I acknowledge receipt of the practice's Notice of Privacy Practices. I authorize the practice to use and disclose my health information for purposes of treating me, obtaining payment, & conducting healthcare operations.

Patient Signature:____ Date:______________________