

WELCOME TO FOUNTAIN OPTOMETRY- Childs Form

Patient Information

Today's Date _____

Last _____

First _____ MI _____

Address _____

City _____ State _____

Zip Code _____

Home Phone _____

Date of Birth _____ Age _____

School _____

Grade _____

Parents Name _____

Parents Day Phone _____

What is the major purpose of this visit?

Any problems with your child's current contact lenses or glasses?

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?
Name of friend or relative _____

If not referred, how did you choose our office?

- Another Dr. _____
- Insurance List
- Saw Sign/Building
- Newspaper/Radio/TV
- Yellow Pages: Which directory? _____
- Web Page: Which Web Site? _____
- Other _____

The mission of Fountain Optometry Family Eye Care is to contribute to a lifetime of healthy vision, providing each patient with the highest quality vision care and consequent quality of life. We will seek continuing education to remain at the forefront of our profession and will offer the latest eye care technology, professional services and products. The

Insurance Information

Please note that most insurances do NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance _____

Subscriber Name _____

Subscriber ID# _____

Subscriber Birth Date _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber ID# _____

Subscriber Birth Date _____

Secondary Medical Insurance _____

Subscribers Name _____

Subscribers ID# _____

Lifestyle Questions

Does your child(check box if your answer is yes)

- ..work at a computer? If yes, How many hours a day?

- ..spend time outdoors? How much? ___Hrs/week
- ..have prescription sunwear?
- ..prefer not to wear their glasses at times?
- ..have more than 1 pair of current Rx eyewear?
- ..participate in any sports? _____

Has your child ever experienced, been diagnosed or treated for any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal Abrasions |
| <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Flash of light | <input type="checkbox"/> Floaters/Spots |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Occasional dryness |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Sunlight Sensitivity |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable glasses | |
| <input type="checkbox"/> Other eye disorders _____ | |

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History		
Name of Child's Physician	_____	
Town	_____	
Date of Last Physical Check-up	_____	
CURRENT MEDICATIONS (Rx or Over the Counter) (List name of medications including eye drops or vitamins)		

Allergies to medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, what medications?	_____	

Has your child had any surgeries?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was your child premature?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any complications at birth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shown Normal Development?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your child ever been diagnosed or treated for the following health problems?		
	Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other:	_____	

Patient Eye History	
Date of Last Eye Exam	_____
Name of Doctor:	_____
Does your child currently wear glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, what kind?	_____
Solutions used:	_____
Are they satisfied with the vision and comfort of their contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your child done any eye patching?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your child had any injury or surgery to the eyes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following:	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (Please check boxes)
	Relationship AND Mother's or Father's side
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____
I certify that I, and/or my dependent(s), have insurance coverage with _____	
Name of Insurance Company(ies)	
And assign directly to Fountain Optometry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.	
Fountain Optometry may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.	
Please sign that you have read and understand the above payment policy and Notice of Privacy Practices	
Signature	_____
Date:	_____