WELCOME TO FOUNTAIN OPTOMETRY- Childs Form

Patient Information

Today's Date ______________________________

Last ____________________________________
First ____________________MI ______________
Preferred Name______________________________
Address__________________________________
City ______________ State __________________
Zip Code __________________________________
Home Phone ________________________________
Date of Birth _________________ Age _________
School _____________________________________
Grade ______________________________________
Parents Name _______________________________
Parents Day Phone ___________________________
Parents Email _______________________________

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 visual needs and wellness of each patient will always be our first priority. Everything we do shall communicate this.

Insurance Information

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

❑..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?

- ❑ Blurry Vision
- ❑ Cataracts
- ❑ Crossed eye/Eye turn
- ❑ Eye Infections
- ❑ Flash of light
- ❑ Glaucoma
- ❑ Headaches
- ❑ Itchiness
- ❑ Macular Degeneration
- ❑ Retinal Detachment
- ❑ Tearing
- ❑ Uncomfortable glasses
- ❑ Other eye disorders___________________________
- ❑ Burning
- ❑ Corneal Abrasions
- ❑ Double Vision
- ❑ Eye Injury
- ❑ Floaters/Spots
- ❑ Grittiness
- ❑ Iritis/Uveitis
- ❑ Lazy Eye
- ❑ Occasional dryness
- ❑ Sunlight Sensitivity
- ❑ Trouble seeing at night

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

Patient Medical History

Name of Childs 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? ❑ Yes ❑ No
If so, what medications?____________________________
____

Has your child had any surgeries? ❑ Yes ❑ No

Was your child premature? ❑ Yes ❑ No

Any complications at birth? ❑ Yes ❑ No

Shown Normal Development? ❑ Yes ❑ No

Has your child ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer:_______________	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological:_____________	❑	❑
Psychological:____________	❑	❑
Respiratory:______________	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

❑ Other: ___________________________________

Patient Eye History

Date of Last Eye Exam_______________________________
Name of Doctor:_____________________________________
Does your child currently wear glasses? ❑ Yes ❑ No

Does your child wear contact lenses? ❑ Yes ❑ No

If so, what kind?___________________________________
Solutions used:____________________________________

Are they satisfied with the vision and comfort of their contact lenses? ❑ Yes ❑ No

Has your child done any eye patching?
❑ Yes ❑ No

Has your child had any injury or surgery to the eyes?
❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
❑ No ❑ Yes (Please check boxes)

	Relationship to you:
Cataracts	❑ ____________________
Glaucoma	❑ ____________________
Macular Degeneration	❑ ____________________
Retinal Problem	❑ ____________________
Blindness	❑ ____________________
Diabetes	❑ ____________________
Hypertension	❑ ____________________
Heart Disease	❑ ____________________
Cancer	❑ ____________________

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: ____