***If viewing this on your computer – you can CLICK ON each blank to enter your values. Then PRINT THE TWO PAGES and bring them with you to our office*. (E-mailing is not secure)**

(This is confidential information, you may leave anything blank if you choose.)

Child's Name: _____ ***Home Phone:*** _____

Address where Child Resides: _____ ***Cell Phone:*** _____

City, State, Zip _____ ***Email:*** _____

CHILD'S

Social Security No. _____

Date of Birth _____ Gender: ☐M ☐F

Present School/Grade: _____

_____

_____

Non-Academic Interests: _____

_____

_____

Is child exposed to second-hand smoke? ☐No ☐Yes

List any of child's relatives that are also seen at this office:

_____

_____

ADULTS

Who is adult at home address (above) responsible for child?

Name: _____ Relation: _____

Cell Phone: _____

Email: _____

Who is adult responsible financially or named as "insured"?

Name: _____ Relation: _____

Street _____ Phone: _____

City: _____ State:_____ Zip Code _____

SSN: _____ DOB:_____

Employer: _____

Vision Benefit Plan: _____

Health Care Plan: _____

NEW PATIENTS ONLY: What current patient referred you to our office?: _____

Date of Last Eye Examination: _____ Where:_____ By Dr.: _____

Do you wear contact lenses? ☐No ☐Yes : How Often/What Type? _____

Do you wear glasses? ☐No ☐Yes : How Often/What Type? _____

Do you use eyedrops? ☐No ☐Yes : How Often/What Type? _____

List any past surgeries, diseases or injuries to the eye(s):	Date	Surgeon/Physician

FAMILY MEDICAL HISTORY : Has the child's Mother, Father or Siblings ever had treatment for (please circle):

Blindness	Yes	No	Cataract	Yes	No	Glaucoma	Yes	No
Macular Degeneration	Yes	No	Retinal Detachment	Yes	No	Amblyopia /Lazy Eye/ Turned Eye	Yes	No
Diabetes	Yes	No	High Blood Pressure	Yes	No	Heart Disease	Yes	No
Thyroid Disease	Yes	No	Arthritis	Yes	No	Liver/Blood Diseases	Yes	No

Financial / Benefit Plan Information:

It is our office policy to expect payment at the time services are rendered. As a courtesy, we will process your benefit plan forms when it is applicable. If you have co-payments, deductibles or other charges outside or above what is determined to be the insurance company's responsibility, you will be responsible for those at this time.

WHEN YOU ARRIVE you will be asked to sign the following, indicating that you AGREE with the following statements:

- I authorize the release of any medical or other information necessary to process my insurance claim. I also request payment of benefits to Fig Garden Optometry Inc. for services and/or materials provided to me by them.
- I was offered a copy of Fig Garden Optometry Inc.'s Notice of Privacy Practices dated January 2, 2014 and signed the Acknowledgement form.

Signed: _____ Date: _____ / _____ / _____

<< TURN OVER TO ENTER CHILD'S PERSONAL MEDICAL INFORMATION >>

MEDICAL HISTORY/REVIEW OF SYSTEMS (Other than Eyes – which is with patient information):

What is the child's general health status? ☐Very Good ☐Good ☐Fair ☐Other:_____

Are they being treated or watched by a physician for any problems in the following areas?

If yes, please explain or describe the problem.

General / Constitutional **Yes / No**_____
(fever, weight loss or gain, tired feelings) _____

Ears, Nose, Throat, Mouth **Yes / No**_____
*(hearing loss, cough, congestion, dry mouth)*_____

Cardiovascular **Yes / No**_____
(hypertension, heart problems, etc) _____

Respiratory **Yes / No**_____
(asthma, emphysema, bronchitis, etc.) _____

Gastrointestinal **Yes / No**_____
(diarrhea, constipation, hernia, ulcers, etc.) _____

Genitourinary / Reproductive **Yes / No**_____
(painful/frequent urination, pregnancy, etc) _____

Musculoskeletal **Yes / No**_____
(arthritis, joint or muscle pain, stiffness, etc) _____

Integumentary / Skin **Yes / No**_____
(pimples, warts, growths, rashes, impetigo) _____

Neurological **Yes / No**_____
(dizziness, double vision, MS, migraines) _____

Psychological **Yes / No**_____
(anxiety, depression, psychosis, etc.) _____

Endocrine **Yes / No**_____
(diabetes, hormone/thyroid treatment, etc) _____

Hematology / Lymphatic **Yes / No**_____
(anemia, bleeding problems, Hodgkins, etc.) _____

Allergic / Immunologic **Yes / No**_____
(hayfever, atopy, other allergies) _____

MEDICATIONS: Is the child taking any prescription medications currently? ☐No ☐Yes, Please list below:

1	5	9
2	6	10
3	7	11
4	8	12

List any ALLERGIES or SENSITIVITIES to medications or substances:_____

_____

If you are filling this form out for the FIRST TIME, do not enter anything below.

Date:	Any Changes to Personal, Social, Medical or Family Information?	Parent Sig.	Doctor Sig.

For Doctor: The information on both sides of this page has been Reviewed by -_____Date:_____