PREMIER EYECARE

CHILD FORM

Patient Information

Today's Date: _____
Last Name: _____
First Name: _____ MI: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____
Gender: M F Date of Birth: _____
Age:_____Grade:_____
Parent's Name:_____
Contact Phone:_____
Contact Email:_____
Texting OK? ❑ Yes ❑ No

Vision Insurance:
❑ VSP ❑ EyeMed ❑ Other: _____
Medical Insurance:
❑ BCBS ❑ Medicare ❑ Priority Health ❑ Aetna
❑ Cigna ❑ Cofinity ❑ Other_____

How did you find out about our office?

❑ Referred:

Who may we thank:_____

❑ Insurance Provider Locator
❑ Internet: Which website? _____
❑ Direct Mail
❑ Other: _____

Privacy Practices for Health Information

NOTICE OF PRIVACY PRACTICES: I have been offered a copy of Premier Eyecare's statement on privacy practices.

AUTHORIZATION TO RELEASE INFORMATION: I authorize Premier Eycare to release any information including diagnosis, records of treatment, or examinations rendered to me or my child during the period of such eye care to 3rd party payers and/or health practitioners.

CONSENT FOR TREATMENT: I hereby grant my authorization and consent for medical treatment and procedures for myself and/or minor children as may be necessary for proper health care.

_____ _____
Parent/Guardian Signature Date

Lifestyle Questions

Are you planning on purchasing glasses today?
❑ Yes ❑ No ❑ Maybe
Are you considering contact lenses for your child?
❑ Yes ❑ No ❑ Maybe
Why do you feel your child needs a visual evaluation?

_____

_____

How long has this problem/difficulty been observed?

_____

Does your child…? (Check all the apply)

❑..wear prescription glasses?

❑..have ultraviolet protection sunwear?

❑..have "back up" prescription eyewear?

❑..wear contact lenses? Brand?

_____

❑..interested in a non-surgical approach to vision correction (Ortho-K)?

❑..have a rapidly increasing prescription?

Dilation Consent/Retinal Photos Consent

Dr. Garretson and the American Optometric Association recommend a **dilated eye examination** to fully assess the health of your eyes. With dilation, drops are placed in the eyes to enlarge the pupils so that the doctor can carefully examine you for eye disease.
Dilation will cause sensitivity to light and will make your near vision temporarily blurry.

___ Yes, I consent to have my child's eyes dilated today.
___No, I do not wish to have my child's eyes dilated, and I agree to hold the practice harmless as a result.

Dr. Garretson also recommends **screening retinal photography** as an extension to your comprehensive eye health and vision exam. This instrument provides important diagnostic information and can be performed without the use of dilating drops. These photographs will become a permanent part of your electronic medical record in our office and form a baseline to track any subtle changes in your eye health from year to year. There is an **additional fee of $39** for retinal photography.

___ Yes, I would like my child to have retinal photos
___ No, I do not want my child to have retinal photos

_____
Parent/Guardian Signature

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

Patient Medical History

Pediatrician: _____
Location: _____
Date of Last Physical: _____

REVIEW OF SYSTEMS
Have you ever been diagnosed for the following health problems?

Constitution
❑ Cancer
❑ Fatigue Syndrome

E□□
❑ Sinusitis
❑ Dry Mouth

N□□□□
□□□□□□□□□□□□□ (Skin)
❑ Multiple Sclerosis
❑ Stroke/CVA
❑ Migraine

P□□□□
Diabetes
❑ Depression
❑ Anxiety Disorder

C□□□□□□□□□
Hematologic/Lymphatic
❑ Hypertension
❑ Heart Disease

R□□□□□□□□□□
Allergic/Immunologic
❑ Asthma
❑ COPD
❑ Sleep Apnea

Gastrointestinal
❑ Crohn's
❑ Ulcer
❑ Acid Reflux

G□□□□□□□□□□□□
❑ Kidney Disease
❑ Prostate Cancer

Musculoskeletal
❑ Arthritis
❑ Ankylosing Spondylitis

❑ Eczema
❑ Rosacea

Endocrine
❑ Type 2 Diabetes
❑ Type 1 Diabetes
❑ Thyroid Dysfunction

❑ Anemia
❑ High Cholesterol

❑ Allergies
❑ Rheumatoid Arthritis
❑ Lupus

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops & vitamins)

_____
_____
_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications? _____
_____
Have you had any surgeries? ❑ Yes ❑ No
If so, please describe: _____
_____

Premature birth? ❑ Yes ❑ No
Any complications during pregnancy? ❑ Yes ❑ No

Birth weight:_____ APGAR score: _____

Shown normal development? ❑ Yes ❑ No

Patient Eye History

Date of Last Eye Exam: _____
Previous Eye Doctor: _____

EYE CONDITIONS
Have you been diagnosed with any of the following?

Cataract	❑
Macular Degeneration	❑
Glaucoma	❑
Diabetes	❑
Diabetic Retinopathy	❑
Dry Eye	❑
Retinal Detachment	❑
Amblyopia (Lazy Eye)	❑
Strabismus (Eye Turn)	❑

Are you currently experiencing any of the following problems?

EYE CONCERNS

Redness	❑
Burning	❑
Itching	❑
Tearing	❑
Discharge	❑

VISION CONCERNS

Blurry Vision without glasses/CLs	❑
Blurry Vision with glasses/CLs	❑
Eyestrain	❑
Eye Pain	❑
Severe light sensitivity	❑
Headache	❑
Double Vision	❑
Loss of Vision	❑
Flashes/Floaters	❑

Family Medical/Eye History (Check all that apply)

Please note any family history (parents, grandparents, siblings, children) for the following conditions:

		Which family member?
Cancer	❑	_____
Type 1 Diabetes	❑	_____
Type 2 Diabetes	❑	_____
Hypertension	❑	_____
Glaucoma	❑	_____
Cataract	❑	_____
Macular Degeneration	❑	_____
Glaucoma	❑	_____
Retinal Problems	❑	_____