



WELCOME TO OUR OFFICE Child Form

Patient Information

Today's Date: _____

Last Name: _____

First Name: _____ MI: _____

Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Contact Cell Phone: _____

Gender: M F Date of Birth: _____ Age: _____

School: _____ Grade: _____

Parent's Name: _____

Occupation: _____

Parent's Name: _____

Occupation: _____

Circle how you would prefer to receive reminders for appointments, eyeglass pickup and special events.

Email
 Text to Cell Phone
 Phone Call /Postcard

Email: _____

Why do you feel your child needs a visual evaluation?

How long has this problem/difficulty been observed?

Lifestyle Questions

Considering contacts for your child? Yes No

Considering Ortho-K for your child? Yes No

Does your child...? (Check all that apply)

... wear prescription glasses?

... have Transitions lenses (darken in the sun)?

... have "back up" prescription eyewear?

... wear contact lenses?

If so, what kind? _____

Solution Used: _____

... have interest in a non-surgical vision correction?

... have a rapidly increasing prescription?

How did you find out about our office?

Where have you seen us? (Check all that apply.)

Insurance List Google

Magazine Ad Our Website

Another Patient: _____

Another Doctor: _____

Other: _____

Patient Eye History

Date of Last Eye Exam: _____

Previous Eye Doctor: _____

Has your child ever experienced, been diagnosed, or been treated for any of the following?
(Check all that apply.)

	Yes	No
Blurry Vision	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Floaters/ Spots/flashes	<input type="checkbox"/>	<input type="checkbox"/>
Color Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to light	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty reading	<input type="checkbox"/>	<input type="checkbox"/>
Misreads words/letter reversals	<input type="checkbox"/>	<input type="checkbox"/>
Eye Fatigue/ Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Pain/ Irritation/Itch	<input type="checkbox"/>	<input type="checkbox"/>
Red Eyes	<input type="checkbox"/>	<input type="checkbox"/>
"Lazy Eye"/ Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>
Eye turn/Crossed eye	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury/ Trauma/ Abrasion	<input type="checkbox"/>	<input type="checkbox"/>
Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Other eye problems: _____		

Family Medical/ Eye History

Have you or a family member been diagnosed with any of the following? Please check all that apply.

	Child	Family member?
Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Eye Turn	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Problems	<input type="checkbox"/>	<input type="checkbox"/>
Other?	<input type="checkbox"/>	<input type="checkbox"/>

The information in this confidential case history form is critical to the evaluation.

Patient Medical History	Additional History																						
<p>Primary Physician: _____</p> <p>Location: _____</p> <p>Date of Last Physical Exam: _____</p> <p><input type="checkbox"/> AUTHORIZATION TO RELEASE INFORMATION:</p> <p>I/We hereby authorize Bright Eyes Family Vision Care to release any medical findings or results for medical benefit to my child's pediatrician.</p> <p>Has your child ever been diagnosed or treated for the following health problems?</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Cancer: _____</td> <td style="width: 50%;"><input type="checkbox"/> Digestive: _____</td> </tr> <tr> <td><input type="checkbox"/> Ear/Nose/Throat</td> <td><input type="checkbox"/> Kidney</td> </tr> <tr> <td><input type="checkbox"/> Sinus Problems</td> <td><input type="checkbox"/> Genitourinary</td> </tr> <tr> <td><input type="checkbox"/> Neuro: _____</td> <td><input type="checkbox"/> Muscle/Bone/Arthritis</td> </tr> <tr> <td><input type="checkbox"/> Psych: _____</td> <td><input type="checkbox"/> Skin: _____</td> </tr> <tr> <td><input type="checkbox"/> Cardio: _____</td> <td><input type="checkbox"/> Diabetes/Endocrine</td> </tr> <tr> <td><input type="checkbox"/> High Blood Pressure</td> <td><input type="checkbox"/> Blood/ Lymph</td> </tr> <tr> <td><input type="checkbox"/> Respiratory/ Asthma</td> <td><input type="checkbox"/> Cholesterol</td> </tr> <tr> <td><input type="checkbox"/> Allergies: _____</td> <td><input type="checkbox"/> Reproductive</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Immune System</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Other Health Problems: _____</td> </tr> </table> <hr/> <p>CURRENT MEDICATIONS (Rx or Over-the-Counter): (List all medications including eye drops, vitamins, etc.)</p> <p>_____</p> <p>_____</p> <p>Allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If so, what medications? _____</p> <hr/> <p>Premature birth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any complications during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes above, please describe: _____</p> <hr/> <p>Shown normal development? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Had physical/developmental therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have had a concussion/brain injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes above, please describe: _____</p> <hr/>	<input type="checkbox"/> Cancer: _____	<input type="checkbox"/> Digestive: _____	<input type="checkbox"/> Ear/Nose/Throat	<input type="checkbox"/> Kidney	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neuro: _____	<input type="checkbox"/> Muscle/Bone/Arthritis	<input type="checkbox"/> Psych: _____	<input type="checkbox"/> Skin: _____	<input type="checkbox"/> Cardio: _____	<input type="checkbox"/> Diabetes/Endocrine	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Blood/ Lymph	<input type="checkbox"/> Respiratory/ Asthma	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Allergies: _____	<input type="checkbox"/> Reproductive	<input type="checkbox"/> Immune System		<input type="checkbox"/> Other Health Problems: _____		<p>How would you describe your child's reading ability?</p> <p>_____</p> <p>Does your child read for fun? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>How many hours of screen time does your child get during an average week? TV _____ Device _____</p> <p>How many hours of outdoor time does your child get on the average week? _____</p> <p>School/after-school activities your child is involved in:</p> <p>_____</p> <p>_____</p> <p>What did your child eat for breakfast today?</p> <p>_____</p>
<input type="checkbox"/> Cancer: _____	<input type="checkbox"/> Digestive: _____																						
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<input type="checkbox"/> Immune System																							
<input type="checkbox"/> Other Health Problems: _____																							
Privacy Practices for Health Information																							
<p>NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of Bright Eyes Family Vision Care's statement on privacy practices.</p> <p>AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Bright Eyes Family Vision Care to release any medical or incidental information that may be necessary for medical benefit or to obtain payment for services. This includes but is not limited to vision plans or medical insurances.</p> <p>CONSENT FOR TREATMENT: I hereby authorize Bright Eyes Family Vision Care to administer diagnostic and medical procedures as may be necessary for proper health care.</p>																							
<p>_____ Parent/ Guardian Signature</p>	<p>_____ Date</p>																						
Dilation Consent																							
<p>Dr. Bonilla-Warford and Dr. Knighton recommend a dilated eye examination to fully assess eye health. With dilation, drops are placed in the eyes to enlarge the pupils so that the doctor can carefully examine both eyes for any diseases. Dilation causes sensitivity to light and makes near vision temporarily blurry. Our office can provide disposable sunglasses. Dilation is routine and does not cost extra.</p> <p>If you have any questions, the Doctor will be happy to answer them. Please INITIAL one option below, indicating that you have read and understood the dilation consent.</p> <p>___ Yes, I consent to have my eyes dilated today.</p> <p>___ No, I do not consent to have my eyes dilated, and I agree to hold the practice harmless as a result.</p>																							
<p>_____ Parent/Guardian Signature</p>																							

Patient Name: _____

FAMILY AND HOME

Please indicate which adult(s) he/she lives with? Mother Father Stepmother Stepfather
 Grandmother Grandfather Other Caretaker _____

Are there other children at home? _____

Has your child ever been through a traumatic family situation (such as divorce, parental loss, severe parental illness)? Yes No If yes, at what age: _____

Does your child seem to have adjusted? Yes No

Is family life stable at this time? Yes No

If no, please explain: _____

IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL/IMPORTANT IN THE TREATMENT OF YOUR CHILD?

IS THERE ANY OTHER INFORMATION YOU DO NOT WANT TO DISCUSS IN FRONT OF YOUR CHILD?

