RANCHO SANTA FE
OPTOMETRY

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Diplomate, A.B.O.

NEW PATIENT INFORMATION - UNDER 18

Last Name _____ First Name _____

Nickname _____ Title _____

Date of Birth _____ Male ☐ Female ☐

Social Security Number _____

Mother's Name _____

Mailing Address _____

Street Address (if different) _____

City _____ State _____ Zip _____

Cell Phone Number _____

Email Address _____

Employer _____ Occupation _____

Father's Name _____

Mailing Address _____

Street Address (if different) _____

City _____ State _____ Zip _____

Cell Phone Number _____

Email Address _____

Employer _____ Occupation _____

How were you referred to our office? ☐ Family ☐ Friend ☐ Online Search

Referred Name *(so we can thank them)* _____

Vision History

Last vision exam date: _____ Were eyeglasses prescribed?_____

Were they worn constantly or for specific tasks? _____

Has your child ever received vision therapy? _____

Please bring all current eyeglasses and/or contact lenses

Visual Symptoms - Have you or anyone else ever noted the following?

- ☐ Distance vision blurred
- ☐ Excessive eye rubbing
- ☐ Excessive blinking
- ☐ Easily fatigued while reading
- ☐ Jerky eye movements
- ☐ Near vision blurred
- ☐ Tilts head when reading
- ☐ Headaches or dizziness
- ☐ Red, sore or itchy eyes
- ☐ Uses finger to read
- ☐ Double vision
- ☐ Watery eyes
- ☐ Loses place easily reading
- ☐ Eyes hurt or tired
- ☐ Light sensitive
- ☐ Skips words when reading
- ☐ Covers or closes an eye
- ☐ Sits close to TV
- ☐ Poor copying from board
- ☐ Eye turn in or out
- ☐ Stumbles over objects
- ☐ Reversals of letters/numbers
- ☐ Holds reading too close
- ☐ Eye/Head injury
- ☐ Poor posture when reading
- ☐ Motion Sick

Have any family members had: (Please indicate relation to child)

Lazy eye _____ Glaucoma _____

Learning Difficulties _____ Neurological Problems _____

Turned eye _____ Poor Vision/High Prescription _____

Attention Problems _____

Child's Early History

Describe the mother's health during pregnancy: _____

Did the mother use any substances or medication during pregnancy? _____

Delivery: Normal ☐ Breech ☐ Caesarian ☐ Forceps ☐ Induced ☐

Was the child premature? _____ If yes, how early? _____

Did the child have any health complications following birth? _____

If any answers are yes please explain: _____

_____

Indicate age your child learned to: Walk _____ Speak _____

Describe any problems your child had during infancy: _____

_____

Medical History

Physician: _____ Phone: _____

Date of last visit: _____

Current Medications: _____

Would you like a report of findings sent to your child's physician? _____

List any serious illnesses your child may have had: _____

Please list any other medical problems: _____

Has the child ever had a hearing evaluation? Y or N Results of the evaluation: _____

Does the child have a history of ear infections? _____

Language

Has the child ever had any speech or language problems? _____

What was the child's first language? _____

Are there any other languages spoken in the home? _____

Behavior

Do you have any concerns regarding your child's behavior? _____

Educational History

Name of School: _____ Grade: _____

Do you have any concerns regarding your child's academic performance? _____

_____

Does your child like school? _____

Did your child skip or repeat any grades? _____

Does your child have trouble with: ☐ Reading ☐ Math ☐ Spelling ☐ Writing

Comments/Explanation: _____

_____

Is your child currently receiving any special help in school? _____

Has your child ever participated in special services like Speech Therapy, Occupational Therapy or Tutoring? (Please Explain) _____

_____

Please add any additional comments you feel are relevant to this exam: _____

_____

_____

VISION INSURANCE

Insured Party Name (as it appears on card) _____

Date of Birth _____ Social Security Number _____

Patient Relationship to Insured _____

Insurance Name _____

Policy Group Number _____ ID No. _____

CONSENT FOR TREATMENT, TO RELEASE INFORMATION & PAYMENT AGREEMENT
I hereby authorize treatment and the release of any information or photographs acquired in the course of my examination or treatment to my referring doctor or insurance company as necessary. I understand that I am financially responsible for services and materials provided to me at the offices of Elizabeth Christensen, O.D. I have received a copy of the privacy statement of Elizabeth Christensen, O.D.

Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay.

Signature of Responsible Party _____ Date _____

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