Welcome to our office!

VISION SOURCE™ PONTIAC · FAIRBURY FAMILY EYE CARE · VISION CENTER

Check yearly...see clearly!

Date _____ /_____ /_____

Last Name _____ First Name _____ Middle Initial _____

Birthdate _____ /_____ /_____ Gender _____ Social Security # _____

School _____ Grade _____ Does your child have an IEP? _____

Parents' Names _____ Email _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

If parents are in different households:

Parent's Name_____

Phone _____

Address _____

_____

With whom, in addition to parent/guardian, may we discuss health related information (include name, relationship and contact phone):

_____

_____

_____

Race _____

Ethnicity: *Hispanic* *Native Hawaiian/Pacific Islander* *Non-Hispanic*

Preferred Language: *English* *Spanish*

First and Last names of immediate family who are patients in our office:

_____

_____

Notice of Privacy Practices — Acknowledgment of Receipt

I acknowledge that a Notice of Privacy Practices has been presented to me. I understand that "take home" copies are available at my request.

SIGNED: _____ Date _____ /_____ /_____

Medical Insurance — Primary: _____

Medical Insurance — Secondary: _____

Vision Plan: _____

We can bill some carriers for you. A list is available. All others must pay at time of service. Payment is expected for all non-covered services you receive. Any balance remaining 90 days after submission to your insurance company becomes your responsibility.

Policyholder Information

Last Name _____ First Name _____ Middle Initial _____

Birthdate _____ /_____ /_____ Soc. Sec. # (Last 4 digits) _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone _____

Patient Guardian or Representative: I authorize the release of information to my insurance company as necessary to process my claim. I authorize payment of benefits to Pontiac Family Eye Care, LLC for services I have received. I agree to pay all collection fees, court costs and reasonable attorney fees if I default on my account. I agree to pay a charge of $35.00 for any check that is returned by my bank. I permit a copy of this authorization to be used in place of the original.

SIGNED: _____ Date _____ /_____ /_____

The **Optomap** is able to detect eye disease that could lead to severe vision loss. *Your doctor requires that all children receive an Optomap Screening retinal photo at every annual examination - even if you think you are seeing clearly.* The $34 screening fee is not typically covered by health insurance or vision plans; however, our experience has proven that this imaging is very important.

_____ (initial) I have read this statement.

Who can we thank for referring you to our office? _____

Please turn over to complete other side.

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Personal Medical and Ocular History

Pediatrician _____ Last Medical Exam _____ (year) Last Eye Exam _____ (year) (location)

Please mark all conditions you have been treated for or experienced:

Allergy
- ☐ Environmental

Cardiovascular
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Vascular Disease
- ☐ High Cholesterol

Constitutional
- ☐ Fever
- ☐ Weight loss/gain

Endocrine
- ☐ Diabetes
- ☐ Thyroid

Mental Health
- ☐ Anxiety
- ☐ Depression

Gastrointestinal
- ☐ Chronic Diarrhea
- ☐ Stomach/Intestine

Genitourinary
- ☐ Kidney / Bladder

Ears, Nose, Throat
- ☐ Sinus Congestion
- ☐ Cold Sores
- ☐ Hearing Loss

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Cancer
- ☐ Sickle Cell Disease

Immunologic
- ☐ Lyme Disease

Integumentary
- ☐ Skin condition

Musculoskeletal
- ☐ Arthritis

Neurological
- ☐ Myasthenia Gravis
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Migraines
- ☐ Brain Tumor

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Respiratory Issues

Ocular
- ☐ Crossed eyes
- ☐ Lazy eye
- ☐ Drooping eyelid
- ☐ Eye infections
- ☐ Styes/chalazion
- ☐ Retinal disease

Cognitive
- ☐ ADD/ADHD
- ☐ Dyslexia
- ☐ Learning disability
- ☐ Reading delays

If you have a condition not listed above, please name or describe below:

_____

_____

List any eye related surgeries or injuries:

_____

_____

_____

List all other **major** surgeries:

_____

_____

_____

Provide us a prepared list of any Rx and "over the counter" medications you take, including dosages, or write them below.

_____

_____

_____

Do you have medication allergies? ☐ NO ☐ YES If yes, list medications:

_____

_____

Any complications with pregnancy, birth/delivery? _____

Total # Weeks Gestatation: ☐ Full-Term (38-41 wks) ☐ Premature (<38 wks) _____ # wks premature

Child's birthweight: _____ lbs _____ oz APGAR score (if known) _____ (scale 1-10)

Any developmental delays? _____

Has the child received any developmental therapy? ☐ Speech ☐ Occupational ☐ Physical ☐ Feeding

Family History

Please mark any family history of the following conditions (parents, grandparents, siblings, or children; living or deceased) :

- ☐ Blindness
- ☐ Cataract
- ☐ Turned Eye (strabismus)
- ☐ Lazy Eye (amblyopia)
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Color "Blindness"
- ☐ Retinal tear or detachment
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Cancer
- ☐ Other _____