Welcome to our office!

Child's name_____Date of birth_____

Address_____City_____Zip_____

Phone number_____

Mother's name_____Father's name_____

Email address_____

Main Reason for Today's Exam_____

_____

Date of Last Eye Exam_____ Were eyes dilated? Yes / No

Please indicate all that pertain to your child's eyes (X) or to an immediate family member's eyes (F):

____surgery	____retinal detachment	____eye turn	____color blindness
____cataracts	____macular degeneration	____lazy eye	____flashes / floaters
____glaucoma	____injury / head trauma	____herpes	____double vision

____eye wanders (if yes, which eye?_____and when?_____)

Pediatrician's name & address_____

_____

Health Conditions_____

Current Medications_____

_____

Whom may we thank for referring you?_____

To whom would you like a report of today's exam sent?_____

_____

In order to provide a thorough exam, dilating eye drops may need to be used.
These eye drops may cause light sensitivity and blurred vision.

_____I give my permission for eye drops to be used *(or)* _____ I understand the reason for drops but refuse them today

I acknowledge receipt of Visual Edge LLC's Notice of Privacy Policies.

Eye exam charges are due in full at time of service, and are non-refundable. Visual Edge, LLC will be happy to assist you in paperwork for reimbursement from your insurance company. We do not bill insurance companies directly.

Please Sign: Patient or Guardian _____Date_____

Please complete reverse side

Was the pregnancy full term? Yes / No

Any complications during pregnancy?_____

Any complications during birth?_____

Did your child crawl? _____Yes _____No At what age did your child walk?_____

Has your child ever had a concussion? _____Yes ____No If yes, when?_____

_____

Have you noticed any of the following?

_____closing one eye _____covering one eye _____eyes frequently red

_____eye rubbing _____poor coordination _____feet turn in when walks

_____tilting head – to the left / right?

_____eye shaking Which eye?_____When?_____

_____eye turn Which eye?_____ When did it first start?_____

Which direction? Up / Down / Out / In Is it occurring less often / more often / the same?

When do you usually notice it?_____

Has your child ever or is your child receiving occupational or physical therapy?_____

_____

_____

What do you hope to learn from this exam?_____

_____

Is there any other information that you feel may be useful?_____

_____

_____

_____

_____