

## WELCOME INVISON EYECARE'S VISION THERAPY ACADEMY

CHILD'S INFORMATION	PARENT'S INFORMATION
Child's Name	Father's Name
Street Address	Occupation
City State Zip	Work Phone: ( ) Ext.
Home Phone: ( )	Mother's Name
Social Security: - -	Occupation
Birthdate (mm/dd/yy):	Work Phone: ( ) Ext.
INSURANCE INFORMATION	REFERRAL INFORMATION
Insurance Information (if applicable)	How did you hear about our office?
Primary carrier:	<input type="checkbox"/> Another Patient (Name)
Insured's Name:	<input type="checkbox"/> Another Doctor (Name)
Insured's ID # Group ID #	<input type="checkbox"/> Newspaper Ad <input type="checkbox"/> Yellow Pages
Supplemental Health Plan: No Yes (Name)	<input type="checkbox"/> TV Ad <input type="checkbox"/> Direct Mailing
Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child Other (Name)	<input type="checkbox"/> Other Promotion (Name)
DEVELOPMENTAL HISTORY	SCHOOL INFORMATION (when applicable)
Full term pregnancy? Normal birth?	Name of school: Grade:
Any complications before, during, or immediately following delivery?	Teacher: Age at time of entrance to 1st grade:
	Does your child like school? Does your child like to read?
	Do you feel he/she is working up to potential?
APGAR Score (if Known)?	What subjects are considered easiest? Most difficult?
Any reactions to Immunizations?	Describe any school difficulties:
Age your child crawled? Age your child walked?	
Age of first speech?	
CURRENT VISUAL HISTORY	FAMILY VISUAL HISTORY
When was last vision examination? Name of Doctor?	Glaucoma None Self Mother, Father, Sibling, Grandparent
Reason for the examination?	Cataracts None Self Mother, Father, Sibling, Grandparent
Were glasses prescribed? How often are they worn?	Macular Degeneration None Self Mother, Father, Sibling, Grandparent
	"Lazy Eye" None Self Mother, Father, Sibling, Grandparent
In what ways does your child seem to have difficulty?	Eye Surgery None Self Mother, Father, Sibling, Grandparent
	Other Eye Diseases None Self Mother, Father, Sibling, Grandparent
	Name of condition?
How does your child complain about his/her vision?	Do any, or did any, members of the family have learning problems? Who?
	Describe:
MEDICAL HISTORY	
Review of Systems	Pediatrician's Name:
Constitutional none cold, flu, fever, tired, weight loss/gain, other:	Date of last medical examination:
Ears, Nose, Throat none allergy, sinusitis, congestion, hearing aids, other:	List any illnesses: age mild severe
Cardiovascular none hypertension, heart attack, heart surgery, other:	
Respiratory none asthma, emphysema, bronchitis, other:	
Gastrointestinal none colitis, Crohns, ulcer, surgery, other:	
Endocrine none diabetes, thyroid, hormone dysfunction, other:	Medications:
Musculoskeletal none arthritis, chronic fatigue, muscle pain, other:	
Genitourinary none kidney, bladder, prostate, STD, other:	
Integumentary none rosacea, acne, psoriasis, eczema, other:	
Neurological none migraines, MS, epilepsy, Parkinsons, other:	
Psychiatric none ADD, OCD, Anxiety, Depression, other:	
Lymphatic/Blood none leukemia, anemia, bleeding disorder, other:	
Your insurance coverage is a contract between you and your insurance company. We only accept assignment from insurance companies whom we are providers for, all others are considered private pay patients. However, we will be more than happy to assist in filing your "out of network" insurance. Reduction or rejection of your insurance claim does not relieve you of your financial obligation. Payment for services rendered to you in good faith is your responsibility. InVision Eyecare Center cannot guarantee insurance coverage.	
X _____	Date _____
<input type="checkbox"/> parent <input type="checkbox"/> adult <input type="checkbox"/> guardian	
revised 8/07	