

Drs. Myers, McDonald, & Johnston Optometrists

YOUTH PATIENT REGISTRATION AND MEDICAL HISTORY

Appt. Date _____

We require payment in full/or insurance co-pays at the time services are rendered or eyewear is ordered. We offer a 5 % discount for paying in full at the time of service when not billing insurance. We accept cash, check, Visa, Discover, Master Card and Care Credit.

If this is your first visit to our office, how did you learn about us? Friend Family Phone Book Website

Other: _____

Patient Name: _____ Birth Date: _____ Gender: M F

Mailing Address _____ Preferred Phone: _____

E-mail address: _____

Emergency Contact Person (other than custodial parent): Name & Phone _____

If your child is a student: School _____ Grade _____

Insurance Information

Do you have vision insurance?	Yes	No	Do you have health insurance?	Yes	No
Name of Insurance Company _____			Contract no. _____		
Mother's Name _____		Birth Date _____	Employer _____		
Father's Name _____		Birth Date _____	Employer _____		
Parent / Guardian Marital Status _____					

Co-pays & deductibles are required on date of service. We will bill your insurance, but can't assure payment. You are fully responsible for payment.

Major Reason for the Eye Exam _____

Please state any learning difficulties _____

Who is your child's physician? _____ Drs. City /Loc. _____

List any medication or eye drops you are allergic to: _____

List any medication you are taking now - *Prescription or over the counter*: _____

Child's General Health	Family Health History	Concerns	School Performance
Has the child ever had or currently have... <input type="checkbox"/> Allergies <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Headaches <input type="checkbox"/> Gastrointestinal Disease <input type="checkbox"/> Drug Reaction <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Respiratory Disease <input type="checkbox"/> Eye Disease <input type="checkbox"/> Eye Surgery <input type="checkbox"/> Other <input type="checkbox"/> None of the above	Has anyone in your family had.... <input type="checkbox"/> Diabetes <input type="checkbox"/> Glaucoma <input type="checkbox"/> Blindness <input type="checkbox"/> Cataracts <input type="checkbox"/> Crossed Eyes <input type="checkbox"/> Lazy Eye <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> None of the above	<input type="checkbox"/> Problem Pregnancy <input type="checkbox"/> Birth Defect Does young person complain of... Yes No <input type="checkbox"/> <input type="checkbox"/> Headaches <input type="checkbox"/> <input type="checkbox"/> Blurred Vision at distance <input type="checkbox"/> <input type="checkbox"/> Blurred Vision w/ reading <input type="checkbox"/> <input type="checkbox"/> Tired or Sore Eyes <input type="checkbox"/> <input type="checkbox"/> Double Vision <input type="checkbox"/> <input type="checkbox"/> Poor Coordination Interests <input type="checkbox"/> Reading <input type="checkbox"/> Computer <input type="checkbox"/> Video Games <input type="checkbox"/> Team Sports <input type="checkbox"/> Music	If the young person is in school: Yes No <input type="checkbox"/> <input type="checkbox"/> Likes School <input type="checkbox"/> <input type="checkbox"/> Working at grade level <input type="checkbox"/> <input type="checkbox"/> Likes Teacher <input type="checkbox"/> <input type="checkbox"/> Are you satisfied with your child's performance? <input type="checkbox"/> <input type="checkbox"/> Is school work below average? <input type="checkbox"/> <input type="checkbox"/> Has a grade been repeated? <input type="checkbox"/> <input type="checkbox"/> Is your child being tutored? <input type="checkbox"/> <input type="checkbox"/> Short attention span? <input type="checkbox"/> <input type="checkbox"/> Would you like a written vision report sent to teacher? If yes, initial here. _____ <input type="checkbox"/> <input type="checkbox"/> May we have permission to dilate your child's eyes if recommended?

Parent/Guardian Signature _____ Date: _____