

## South County Eye Care Optometric Group

23002 Lake Center Drive, Lake Forest CA 92630

### WELCOME TO OUR OFFICE

This personal vision and health information will help us give your child the most complete a thorough vision examination possible. All information is of course, confidential.

**Parent's Name** \_\_\_\_\_ Soc. Sec# \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone No. (home) ( ) \_\_\_\_\_ (work) ( ) \_\_\_\_\_  
**E-Mail Address:** \_\_\_\_\_  
 Employed by \_\_\_\_\_  
 Occupation \_\_\_\_\_

**Child's Full Name:** \_\_\_\_\_ Nickname: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sibling's Ages: \_\_\_\_\_

**Child's Medical Condition:** \_\_\_\_\_ Check here if **no** medical problem.

\_\_\_\_\_

List any serious illness/injury and your child's age at time of each. \_\_\_\_\_ **Check if none.**  
 Age: \_\_\_\_\_ Illness: \_\_\_\_\_  
 Age: \_\_\_\_\_ Illness: \_\_\_\_\_  
 Age: \_\_\_\_\_ Illness: \_\_\_\_\_

Please list your child's medications and their purposes. \_\_\_\_\_ **Check if none.**

\_\_\_\_\_

Child's Pediatrician or Physician: \_\_\_\_\_  
 Address: \_\_\_\_\_

**Child's Developmental History:**  
 Normal Pregnancy? Yes No Normal Birth? Yes No  
 Complications? \_\_\_\_\_

Age of crawling: \_\_\_\_\_ Age of walking: \_\_\_\_\_ Did motor skills develop normally? \_\_\_\_\_  
 If not, explain: \_\_\_\_\_

**Child's School History:**  
 Does your child like school? \_\_\_\_\_ Teacher? \_\_\_\_\_ Classmates? \_\_\_\_\_  
 Reading? \_\_\_\_\_ Writing? \_\_\_\_\_ Math? \_\_\_\_\_  
 Is attendance regular? \_\_\_\_\_ Any grades repeated? \_\_\_\_\_  
 Best subject \_\_\_\_\_ Worst subject \_\_\_\_\_  
 Any behavior or social concerns? \_\_\_\_\_

How well does your child do with school work? \_\_\_\_\_

\_\_\_\_\_

**Child's Vision History:**  
 Please state the primary reason for today's examination: \_\_\_\_\_  
 \_\_\_\_\_

Last vision examination \_\_\_\_\_ Results (Glasses  Contacts  Other  \_\_\_\_\_

List any **serious** vision or eye condition(s) and your child's age at the time.  
 \_\_\_\_\_ **Check if none.**  
 Age: \_\_\_\_\_ Condition: \_\_\_\_\_  
 Age: \_\_\_\_\_ Condition: \_\_\_\_\_  
 Age: \_\_\_\_\_ Condition: \_\_\_\_\_

**Has your child received any of the following vision care?**  
 \_\_\_\_\_ **Check if none.**

Specific care	Age	Comments
Eye Exam/Glasses	_____	_____
Vision Therapy/Patching	_____	_____
Eye surgery/Eye Drops	_____	_____

**Have you or anyone else noticed (or has your child reported) any of the following?**  
**Please check all that apply.**

<input type="checkbox"/> Reading close	<input type="checkbox"/> Closing/covering one eye	<input type="checkbox"/> Difficulty seeing far away
<input type="checkbox"/> Rubbing of eye	<input type="checkbox"/> Tilting head when reading	<input type="checkbox"/> Frequent headaches
<input type="checkbox"/> Eyes hurt or tire	<input type="checkbox"/> Reverses letters or words	<input type="checkbox"/> Inattentive or daydreams
<input type="checkbox"/> Skips/re-reads	<input type="checkbox"/> Eye turning in & out	<input type="checkbox"/> Vocalizes when reading
<input type="checkbox"/> Avoids reading	<input type="checkbox"/> Reports seeing double	<input type="checkbox"/> Blur when reading
<input type="checkbox"/> Other, Explain: _____		

\_\_\_\_\_

\_\_\_\_\_

Any additional comments regarding your child that you may feel we should be aware of: \_\_\_\_\_  
 \_\_\_\_\_

**Whom may we thank for referring you to our office?**  
 \_\_\_\_\_

**Vision Insurance Co.** \_\_\_\_\_  
 Member's Name: \_\_\_\_\_ Soc. Sec# \_\_\_\_\_  
**Medical Insurance Co.** \_\_\_\_\_  HMO  PPO  EPO  
 Policy # \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 We have a list of medical/vision insurances that we bill directly for services rendered. If your insurance does not provide payment within 60 days, **you are responsible** to pay in full. If your insurance is not on the list, please ask us for a "**super bill**" so that you may submit to your insurance directly for reimbursement. You are responsible to pay in full at the time products or services are provided.

**Signature** \_\_\_\_\_

(Office Use Only) \_\_\_\_\_  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 M F \_\_\_\_\_  
 Nickname \_\_\_\_\_  
 Age \_\_\_\_\_  
 (HM) \_\_\_\_\_  
 Date \_\_\_\_\_