

Medical Record # \_\_\_\_\_  
(office use only)

**PEDIATRIC MEDICAL INFORMATION**  
(Infant to 17 Years Old)

Date \_\_\_ / \_\_\_ / \_\_\_

Child's name: \_\_\_\_\_ / \_\_\_\_\_  
(last) (first and preferred)

Chief concern about child's eyes: \_\_\_\_\_  
\_\_\_\_\_

When did symptoms start? \_\_\_\_\_

**FAMILY HISTORY** Please circle all that apply. If "yes", please provide information.

Do any of the following run in your family:

|                              |     |    |
|------------------------------|-----|----|
| Crossed eyes.....            | YES | NO |
| Amblyopia (lazy eye).....    | YES | NO |
| Birth defects.....           | YES | NO |
| Neurological disease.....    | YES | NO |
| Other childhood disease..... | YES | NO |

| NAME  | RELATION | DISEASE |
|-------|----------|---------|
| _____ | _____    | _____   |
| _____ | _____    | _____   |
| _____ | _____    | _____   |

Number of brothers and/or sisters and their ages: \_\_\_\_\_  
\_\_\_\_\_

**BIRTH HISTORY** Please circle all that apply. If "yes", please provide information.

|  |     |    |
|--|-----|----|
| Was the patient premature?.....  | YES | NO |
| Birth weight _____ Weeks of gestation _____  |     |    |
| Were there any problems with the pregnancy? .....                                    | YES | NO |
| Was there any trouble with delivery?.....  | YES | NO |
| Was there any breathing or feeding problem in the first<br>few months? .....         | YES | NO |
| Was there any trouble or delayed sitting, walking,<br>talking, or development? ..... | YES | NO |
| Are there any unresolved school difficulties? .....                                  | YES | NO |

\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY** Please circle all that apply. If "yes", please provide information.

Has the patient's primary care doctor suspected or diagnosed any **serious illness**? ..... YES NO

Does the patient take **medication** or treatments frequently or regularly? If yes please list medication on lines below. .... YES NO

| <u>MEDICATION</u> | <u>STRENGTH</u> | <u>HOW MANY TIMES A DAY?</u> |
|-------------------|-----------------|------------------------------|
|                   |                 |                              |
|                   |                 |                              |

Is he/she known to be **allergic** to any medications? ..... YES NO  
to any environmental conditions? ..... YES NO

If yes list \_\_\_\_\_

Has the patient had all the age appropriate immunizations (up to age 16)? ..... YES NO

Has the patient's growth and development, such as fine motor control, gross motor control, speech, etc., been within normal limits?  
YES\_\_\_\_ NO\_\_\_\_ (If your answer is no, give details below on the blank lines)

\_\_\_\_\_

*Please circle all that apply.*

Is your child receiving:      physical      occupational      speech therapy?

**EYE HISTORY** Please circle all that apply. If "yes", please provide information.

Has the patient ever been seen by another eye Dr.?..... YES NO

By \_\_\_\_\_ Date of last exam \_\_\_\_\_

Has he/she ever had an eye injury?..... YES NO  
an eye operation?..... YES NO

Are glasses worn? ..... YES NO  
Age first worn \_\_\_\_\_

Are contact lenses worn?.....YES NO  
Age first worn \_\_\_\_\_

**SCHOOL HISTORY** If your child is in school please circle.

Are there any unresolved difficulties in school?..... YES NO

Grade \_\_\_\_\_

**Does the child currently have any problems in the following areas? Please circle all that apply. If "yes", please provide information in space provided at end of list.**

**CONSTITUTIONAL SYMPTOMS**

|             |     |    |         |     |    |
|-------------|-----|----|---------|-----|----|
| Fever       | YES | NO | Fatigue | YES | NO |
| Weight Loss | YES | NO |         |     |    |

**EYES**

|                  |     |    |                   |     |    |
|------------------|-----|----|-------------------|-----|----|
| Loss of vision   | YES | NO | Itching           | YES | NO |
| Blurred vision   | YES | NO | Burning           | YES | NO |
| Distorted vision | YES | NO | Excess tearing    | YES | NO |
| Mucous discharge | YES | NO | Light sensitivity | YES | NO |
| Redness          | YES | NO | Eye pain          | YES | NO |

**EAR, NOSE, MOUTH, THROAT**

|               |     |    |                     |     |    |
|---------------|-----|----|---------------------|-----|----|
| Sinus disease | YES | NO | Difficulty learning | YES | NO |
|---------------|-----|----|---------------------|-----|----|

**RESPIRATORY**

|               |     |    |        |     |    |
|---------------|-----|----|--------|-----|----|
| Chronic cough | YES | NO | Asthma | YES | NO |
|---------------|-----|----|--------|-----|----|

**CARDIOVASCULAR**

|              |     |    |                              |     |    |
|--------------|-----|----|------------------------------|-----|----|
| Heart murmur | YES | NO | Rapid or irregular heartbeat | YES | NO |
|--------------|-----|----|------------------------------|-----|----|

**GASTROINTESTINAL**

|           |     |    |               |     |    |
|-----------|-----|----|---------------|-----|----|
| Hepatitis | YES | NO | Bowel disease | YES | NO |
| Diarrhea  | YES | NO |               |     |    |

**GENITOURINARY**

|                    |     |    |  |  |  |
|--------------------|-----|----|--|--|--|
| Bladder infections | YES | NO |  |  |  |
|--------------------|-----|----|--|--|--|

**MUSCULOSKELETAL**

|             |     |    |            |     |    |
|-------------|-----|----|------------|-----|----|
| Muscle pain | YES | NO | Joint pain | YES | NO |
| Arthritis   | YES | NO |            |     |    |

**PSYCHIATRIC**

|            |     |    |         |     |    |
|------------|-----|----|---------|-----|----|
| Depression | YES | NO | Anxiety | YES | NO |
|------------|-----|----|---------|-----|----|

**ENDOCRINE**

|                  |     |    |                     |     |    |
|------------------|-----|----|---------------------|-----|----|
| Excessive thirst | YES | NO | Intolerance to heat | YES | NO |
|------------------|-----|----|---------------------|-----|----|

**Please circle all that apply. If "yes", please provide information.**

**NEUROLOGICAL**

|                       |     |    |                       |     |    |
|-----------------------|-----|----|-----------------------|-----|----|
| Learning Disabilities | YES | NO | Headaches             | YES | NO |
| Seizures              | YES | NO | Weakness arms/legs    | YES | NO |
| Strokes               | YES | NO | Speech problems       | YES | NO |
| Migraine              | YES | NO | Dizziness             | YES | NO |
| Difficulty chewing    | YES | NO | Difficulty swallowing | YES | NO |

**Please circle all that apply. If "yes", please provide information.**

**HEMATOLOGIC/LYMPHATIC**

|               |     |    |                   |     |    |
|---------------|-----|----|-------------------|-----|----|
| Blood disease | YES | NO | Bleeding problems | YES | NO |
| Anemia        | YES | NO | Leukemia          | YES | NO |

**ALLERGIC/IMMUNOLOGIC**

|                    |     |    |       |     |    |
|--------------------|-----|----|-------|-----|----|
| Seasonal allergies | YES | NO | Hives | YES | NO |
|--------------------|-----|----|-------|-----|----|

**DRUG EXPOSURE**

YES NO

**AIDS/HIV**

YES NO

Explanation of Problem: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the patient have any medical problems or symptoms we have not asked you about?

YES \_\_\_\_\_ NO \_\_\_\_\_ **If "yes", please provide information:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Information Reviewed By:

Initials:

Date:

**All information on this form is confidential.**

## **PEDIATRIC PATIENT INFORMATION**

**Patient's name** \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
(last) (first and preferred)

Age \_\_\_\_\_ Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Home address** \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
Home phone number \_\_\_\_\_ Social security# \_\_\_\_\_

**Father's name** \_\_\_\_\_ Marital status: S M W D SEP  
Address and phone (*if different from patient*) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
Home phone number \_\_\_\_\_ Social Security # \_\_\_\_\_  
Father's employer \_\_\_\_\_ Position \_\_\_\_\_  
Work phone number \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Cell phone number \_\_\_\_\_ Email address: \_\_\_\_\_

**Mother's name** \_\_\_\_\_ Marital status: S M W D SEP  
Address and phone (*if different from patient*) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
Home phone number \_\_\_\_\_ Social Security # \_\_\_\_\_  
Mother's employer \_\_\_\_\_ Position \_\_\_\_\_  
Work phone number \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Cell phone number \_\_\_\_\_ Email address: \_\_\_\_\_

**Emergency contact** \_\_\_\_\_ Phone \_\_\_\_\_  
(Name and number of person other than parent or guardian)

**Child's primary care physician** \_\_\_\_\_ City \_\_\_\_\_

Whom can we thank for recommending us?  
Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

**Primary insurance company** \_\_\_\_\_  
Individual ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Company address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policyholder's name \_\_\_\_\_ D.O.B. \_\_\_\_\_

**Secondary insurance company** \_\_\_\_\_  
Individual ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Company address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policyholder's name \_\_\_\_\_ D.O.B. \_\_\_\_\_

**SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS,  
FINANCIAL AGREEMENT**

Patient Name: \_\_\_\_\_

Chart Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

*I accept full financial responsibility for any charges incurred today if:*

1. The services rendered or supplies used/purchased are not covered under my insurance plan;
2. My insurance plan requires that I pay a deductible, co-payment, or there is a co-insurance;
3. There are charges that have resulted because I have failed to provide current and valid insurance policy information; or
4. My insurance plan requires that I obtain a referral prior to my visit and I do not have one in place.

*I agree:*

1. Payment be made to The Eye Care Group, PC (TECG) by my insurance carrier for services rendered or product received;
2. I understand that TECG may use and disclose medical information about me for services and procedures so they may be billed and collected from an insurance agency or any other third party;
3. To pay for my copay and other charges that are not covered by my insurance carrier today or make financial arrangements satisfactory to TECG for payment;
4. If I am not able to pay TECG for balances within 30 days, to pay a 1% interest charge, compounded, per month for my balance.
5. To pay for any returned check fees incurred by TECG.
6. If I am the parent/guardian bringing in a child for treatment, that I am responsible for all fees incurred by the child.
7. If an account is sent to collection or attorney for collection, to pay collection expenses and attorney's fees.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_