Pediatric Patient Information Form
Please complete the entire form below.
If a question does not apply to you, please enter "NA" as your answer.

Choose the location of your scheduled appointment: ☐ Tyler ☐ Longview ☐ Athens ☐ Henderson

Patient Information

Child's First Name: ___________________________Child's Last Name:________________________ Middle Initial:______

Address/P.O.Box/Apt #:____

City:___________________________ State: ____________________ Zip:____________________________

Home Phone:______________________________ Cell/Other:_______________________________________

Parent's Email:____

Child's Date of Birth:______________________________ Age:___________

Sex: _____ Male _____ Female

Child's Social Security #:___________________________________ Marital Status:___________________________

Mother's/Guardian's Name:____Date of Birth: _____________________

Mother's/Guardian's Social Security #:____

Mother's/Guardian's Home Phone # (if different):____

Mother's/Guardian's Work Phone #:____

Mother's/Guardian's Employer and Address:____

Father's/Guardian's Name:____Date of Birth: _____________________

Father's/Guardian's Social Security #:____

Father's/Guardian's Home Phone # (if different):____

Father's/Guardian's Work Phone #:____

Father's/Guardian's Employer and Address:____

Insurance Information

Primary Insurance Company Name:____

Policy #:____

Primary Insurance Policyholder:____

Secondary Insurance Company Name:____

Policy #:____

Secondary Insurance Policyholder:____

Additional Insurance Company Name:____

Policy #:____

Additional Insurance Policyholder:____

I declare that I have no insurance policies other than what is listed above: _____ Yes _____ No

Date of Declaration (today's date):____________________

If referred by a Medical Doctor or Optometrist, please list:

Referring Physician's Name:____________________________ City:_________________________

Emergency Contact Name: _____________________________ Phone #:______________________

List any previous eye surgeries along will all other surgeries:_________________________________

____

Communication

___ You may leave confidential clinical/surgical information on my answering machine or voicemail

Daytime Phone:________________________ Evening Phone:______________________________

___ You may leave confidential clinical/surgical information on the following additional methods of communication, ie: cell phone, voice mail at work, etc…

____

Patient/Legal Guardian Signature:____

Date:______________ Witness Signature:____

Medical Information

Date:________________ Referred By:_____________________________________

Patient Name:_____________________________ Date of Birth:____________________________________

Optometrist:______________________________ Family Dr./PCP:___________________________________

Personal Medical History

Do you wear glasses? _____ Yes/type__________________ _____ No

Do you wear contacts? _____ Yes/type___________________ _____ No

Allergies to medications:____

Eye medications/drops: List all eye drops or eye medications that you take including the dosage and strength:____

List all other medications, vitamins and/or herbs that you take. Please include the dosage and strength of each:____

Have you been diagnosed with any of the following:

___ Blindness

___ Glaucoma

___ Cataracts

___ Retinal Disorder

___ Crossed Eyes/Strabismus

___ Lazy Eye/Amblyopia

___ Cancer

___ Diabetes

___ High Blood Pressure

___ Heart Disease

___ Asthma

___ Thyroid Disease

___ Autoimmune Disorders

___ Other:____

List any previous eye surgeries along with all other surgeries:

____

Family Medical History

Please check all that apply, and indicate their relationship to you:

___ Blindness _________________

___ Glaucoma ________________

___ Cataracts_________________

___ Retinal Disorder__________________

___ Crossed Eyes/Strabismus________________

___ Lazy eye/Amblyopia________________

___ Cancer___________________________

___ Diabetes__________________

___ High Blood Pressure___________________

___ Heart Disease_________________________

___ Asthma__________________

___ Thyroid Disease______________________

___ Autoimmune Disorders________________

___ Other:________________________________

Social History

Current Occupation:____

Do you use tobacco products? ___ Yes ___ No

Do you drink caffeine? ___ Yes ___ No

Do you drink alcohol? ___ Yes ___ No ___ Occasionally ___ Daily

Do you use recreational drugs? ___ Yes ___ No ___ In the past Type:_________

Please list your pharmacy or choice of pharmacy below:

- This information will be added into your electronic medical records.

Pharmacy Name:____________________________________ Phone #:_______________________________

Address or approximate location:____