

# Total Vision Eye Care

## New Patient Intake Form Child (age 3-16)

Updated May 2023

### General Information

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

Is this a first eye examination? Yes \_\_\_ No \_\_\_ If not, what is the approximate date of the last eye exam: \_\_\_\_\_

**Parent/Guardian Contact Information** Names of Parents/Guardians: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home# \_\_\_\_\_ Cell#1/Name: \_\_\_\_\_ Cell#2/Name: \_\_\_\_\_

### Eye Health, Medical Health, Family History

**Child's Medical History** (current or previous) check all that apply:

No Problems \_\_\_ Amblyopia (lazy eye) \_\_\_ Diabetes \_\_\_ Strabismus (eye turn) \_\_\_ Other: \_\_\_\_\_

List any eye surgeries or injuries: \_\_\_\_\_

List any medical conditions: \_\_\_\_\_

List their current medications: \_\_\_\_\_

List any medicine allergies: \_\_\_\_\_

List any other allergies: \_\_\_\_\_

List any family eye history: \_\_\_\_\_

Have they ever had to do Vision Therapy (eye exercises)? Yes \_\_\_ No \_\_\_

Have they ever had to do any patching (wear a patch over one eye)? Yes \_\_\_ No \_\_\_

### Current Vision & Eye Care Needs

Do they currently wear glasses? Yes \_\_\_ No \_\_\_

What do they use their glasses for? Distance \_\_\_ Reading \_\_\_ Computer \_\_\_ All the Time \_\_\_ N/A \_\_\_

What is the **main reason** for your visit: \_\_\_\_\_

List their sporting activities/hobbies: \_\_\_\_\_

- **CONSENT FOR TREATMENT:** I/We hereby authorize Total Vision Eye Care to administer diagnostic and medical procedures as may be necessary for proper ocular health care.
- **OFFICE POLICY ON PAYMENT:** I understand that I am responsible for payment of all charges. As a courtesy, my insurance may be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company at the time of billing. I authorize insurance benefits to be paid directly to the provider, if I request it.
- **CONSENT FOR EMAIL COMMUNICATION:** I consent to Total Vision Eye Care sending me information about Total Vision Eye Care by e-mail and other electronic communications. I understand I can withdraw my consent at any time by contacting Total Vision Eye Care at J2-308 Taunton Rd. E., Whitby, ON, L1R 0H4, 905-620-0660. My email will not be used for marketing unless I request it, and will not be provided to a third party.
- **CANCELLATION POLICY:** I agree to provide 24 hours notice for any appointment cancellation. I understand that if I do not, I will be required to pay a rebooking fee before being able to book any household appointments. The cost will be \$50.00 or the full fee of the missed appointment.

Parent/Guardian Signature: \_\_\_\_\_

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