Total Vision Eye Care

New Patient Intake Form Child (under 3)

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

Infant Eye Health

Is your child able to recognize you from across the room? Yes ___ No ___

Is your child able to see small objects (ie: size of a pea)? Yes ___ No ___

Does your child's eye turn in or out? Yes ___ No ___ Not Sure ___

Does your child's eye water excessively? Yes ___ No ___ Not Sure ___

Prenatal/Postpartum History

Were there complications during pregnancy? Yes ___ No ___ Not Sure ___ If yes, please explain _____

Were there complications during delivery? Yes ___ No ___ Not Sure ___ If yes, please explain _____

Were forceps used during delivery? Yes ___ No ___ Not Sure ___

Was your baby born prematurely? Yes ___ No ___ If yes, how many weeks? _____

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:_____

Current Vision & Eye Care Needs

What is the main reason for the appointment?

Routine exam ___ Concerns (please list) _____

- **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:_____