TOTAL VISION EYE CARE - CHILD WELCOME (3-16)

General Information:

Child Name: _____ OHIP# _____ _____ _____ Version Code: ___ ___
Address: _____ DOB: _____
Name of Parent/Guardian: _____ Family Doctor: _____
Date of Last Eye Exam: _____ Date of Last Medical Exam: _____ Grade at School: _____
Parent/Guardian Contact - Email: _____ Home#: (____)_____ Cell#: (____)

Check how you heard about our office.

☐ Office Sign ☐ Online Search ☐ Social Media ☐ Referred by (name) _____ Other _____

Check off your preferred method of contact.

Home Phone: ☐ Cell Phone: ☐ Work Phone: ☐ Email: ☐ Text message: ☐

Please check here if you would like to receive information regarding in-office promotions ☐

Eye, Health and Family History:

CHILD'S EYE HEALTH

Check any conditions they **previously had or currently have**:

☐ Diabetes
☐ Glaucoma
☐ Corneal Disease
☐ Cataracts
☐ Retinal Disease
☐ Strabismus (eye turn)
☐ Visual FIeld Defects (peripheral vision)
☐ Amblyopia (lazy eye)
☐ No problems

FAMILY HISTORY

Mark M for Maternal, and P for Paternal

_____ Diabetes
_____ High Myopia
_____ High Blood Pressure
_____ Cancer
_____ Glaucoma
_____ Amblyopia (lazy eye)
_____ Strabismus (eye turn)
_____ Cataracts
_____ Macular Degeneration
_____ No problems

CHILD'S CURRENT VISION

Glasses:

Do they currently wear glasses? ☐ **Y** ☐ **N** *if yes, answer the questions below; if no, continue to next section:*
What do they use their glasses for? ☐ **Distance** ☐ **Reading/Computer** ☐ **Wear all the time**
Do they currently have a back up pair? ☐ **Y** ☐ **N**

Vision Therapy:

Have they ever had to do any "eye exercises"? ☐ **Y** ☐ **N**

Patching:

Have they ever had to wear a patch over one eye? ☐ **Y** ☐ **N**

List any eye surgeries or injuries (or write none): _____
List any medical conditions (or write none): _____
List current medications (or write none): _____
List any medicine allergies (or write none): _____
List any other allergies (or write none): _____

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Vision and Eye Care Needs:

Check off any troubles they are having.

☐ Blurry Distance Vision	☐ Poor night vision	☐ Eye Strain	☐ Glare or reflections
☐ Blurry near vision	☐ Headaches	☐ Double Vision	☐ Trouble reading/learning
☐ Itchiness	☐ Burning	☐ Watering eyes	☐ Dry eyes
☐ Floaters	☐ Flashes of light	☐ Gritty feeling	☐ Redness
☐ Soreness or pain	☐ Light sensitivity		

Other (explain):_____

How many hours do they spend on a device per day? _____

How many hours do they spend outdoors per week? _____

If they wear glasses or sunglasses, do they filter 100% of UV light? ☐ **Yes** ☐ **No** ☐ **N/A** ☐ **Unsure**

What is the main reason for their visit with our office :_____

Please list their sporting activities / hobbies or write none:_____

Eye Care For Your Family

We would like to ensure that all of your family members are also receiving the highest quality eye care available. To help us make the appropriate recommendation, please list the names and ages of any children that are still living at home or check Not Applicable. Thank you very much.

☐ **Not applicable**

Name	Age	Date of last known eye examination

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Total Vision Eye Care to release any medical or incidental information that may be necessary for medical benefit of in processing applications for submissions to my insurance company.
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. 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.

Updated October 2021

SIGNATURE: _____ DATE: _____