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

Please fill out *all* sections completely.

General Information:

Child Name: ____________________ OHIP# ____________ Version Code: ________
Address: ____________________ DOB: ____________ School Grade: ________
Family Doctor: ____________________ Date of last Medical Exam: ____________
Is this a first eye examination?: Yes ☐ No ☐ If not, Date of Last Eye Exam: ____________
Parent/Guardian Contact Information. Names of Parents/Guardians: ____________
Email: ____________
Home#: ________ Cell#1/Name: ____________ Cell#2/Name: ____________

How did you hear 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 (once or twice a year) ☐

Eye, Health and Family History:

CHILD'S EYE HEALTH

Current or previous:

- ☐ Diabetes
- ☐ Glaucoma
- ☐ Corneal Disease
- ☐ Cataracts
- ☐ Retinal Disease
- ☐ Strabismus (eye turn)
- ☐ Peripheral Vision Defects
- ☐ Amblyopia (lazy eye)
- ☐ No problems

FAMILY HISTORY

- ☐ 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** you have (or write none): ____________
List your **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 you 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 you spend on a device per day? **Average:** ____________

How many hours do you spend outdoors per week? **Average:** ____________

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

What is the **main reason** for your visit:____

List your **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 N/A. Thank you very much. **N/A** ☐

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 or 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.
- **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.

Updated February 2023

PARENT/GUARDIAN SIGNATURE: ______________________________ **DATE:** ____________