



Today's Date: \_\_\_/\_\_\_/\_\_\_

To be used if patient is a MINOR

### PATIENT INFORMATION

Patient First Name: \_\_\_\_\_ Middle Initial: \_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Sex: \_\_\_ Male \_\_\_ Female

Parent(s) Names:

Mother: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Father: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

#### How did you first become aware of our practice?

\_\_\_ Friend or Family (Name): \_\_\_\_\_ \_\_\_ Practice Website \_\_\_ Direct Mail \_\_\_ Yellow Pages  
\_\_\_ Medical Doctor (Name): \_\_\_\_\_ \_\_\_ Insurance Company \_\_\_ Drive By \_\_\_ Other

### INSURANCE INFORMATION

**VISION** Insurance Co.: \_\_\_\_\_ **MEDICAL** Insurance Co.: \_\_\_\_\_

Insured Member Name: \_\_\_\_\_

Insured Member Social Security #: \_\_\_ - \_\_\_ - \_\_\_ Insured Date of Birth \_\_\_/\_\_\_/\_\_\_

Employer: \_\_\_\_\_

Identification # \_\_\_\_\_ Group # \_\_\_\_\_

Is responsible party's address the same as the minor's? \_\_\_ Y \_\_\_ N, if No, please provide below:

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

#### PLEASE SIGN THE FOLLOWING STATEMENT WHICH ALLOWS DR. TAYLOR TO FILE WITH YOUR INSURANCE COMPANY:

I, the undersigned, certify that I (or my dependent) have insurance coverage with the company previously listed, and assign all insurance benefits directly to Dr. Christy Taylor/TaylorMade Eyecare & Optical. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance submissions.

SIGNED: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

#### HIPAA ACKNOWLEDGEMENT:

My signature below indicates that I have received, reviewed, and understand my right to privacy under HIPAA guidelines.

\_\_\_ I have received a copy. \_\_\_ I waived my right to a copy. SIGNED: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

## EYE HEALTH HISTORY

Date of Last Eye Exam: \_\_\_\_\_ Name of Eye Doctor or Location: \_\_\_\_\_

Please mark any problems below, as best you can, that they are currently experiencing:

- |  |  |  |   |   |
|--|--|--|---|---|
| <input type="checkbox"/> Blind Spot(s) in Vision     | <input type="checkbox"/> Crossed Eyes  | <input type="checkbox"/> Floaters                | <input type="checkbox"/> Loss of Vision-Temp  | <input type="checkbox"/> Red Eyes         |
| <input type="checkbox"/> Blurred Vision-Distance     | <input type="checkbox"/> Dizzy Spells  | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Seeing Flashes   |
| <input type="checkbox"/> Blurred Vision-Intermediate | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Migraines            | <input type="checkbox"/> Seeing Halos     |
| <input type="checkbox"/> Blurred Vision-Near         | <input type="checkbox"/> Dry Eyes      | <input type="checkbox"/> Itchy Eyes              | <input type="checkbox"/> Mucous Discharge     | <input type="checkbox"/> Sty(e)s          |
| <input type="checkbox"/> Burning Eyes                | <input type="checkbox"/> Eye Injury    | <input type="checkbox"/> Light Sensitivity       | <input type="checkbox"/> Painful Eye(s)       | <input type="checkbox"/> Twitching Eyelid |
| <input type="checkbox"/> Cataract(s)                 | <input type="checkbox"/> Eye Strain    | <input type="checkbox"/> Loss of Vision-Constant | <input type="checkbox"/> Poor Night Vision    | <input type="checkbox"/> Watery Eyes      |

How many total hours per day does the minor spend at a computer or playing video games? \_\_\_\_\_ How many days per week? \_\_\_\_\_

Please mark any of the following symptoms the minor notices after extended computer/video game use:

- Blurred Vision  Eyestrain  Dry Eyes  Glare Sensitivity  Headaches  Neck/Backaches  Distance Vision Blurred

**Does the minor currently wear glasses?**  Yes  No

If **YES**, do they wear them:  Full-time  Part-time  Distance Only  Near Only

**Does the minor currently wear contact lenses?**  Yes  No

If **YES**, please answer the following questions:

What brand or type of contact lenses do they wear? \_\_\_\_\_ How old are their current lenses? \_\_\_\_\_

How often do they replace their lenses? \_\_\_\_\_ What is their normal wear schedule? \_\_\_\_\_ hours/day \_\_\_\_\_ days/week

Are they having any problems with their contact lenses?  Dry out easily  Uncomfortable  Blurry Far Vision  Blurry Near Vision

What brand of solution do their lenses soak in at night? \_\_\_\_\_

Do their back-up glasses have their current prescription?  Yes  No  They do not have back-up glasses

## MEDICAL HISTORY

Date of last medical exam: \_\_\_\_\_ Name of primary care physician: \_\_\_\_\_

**Please mark any of the following health conditions that apply to the minor OR family (indicate which family members):**

	SELF	FAMILY		SELF	FAMILY		SELF	FAMILY
Blindness	___	___	Bleeding Disorder	___	___	Hepatitis (Type___)	___	___
Glaucoma	___	___	Cancer	___	___	High Blood Pressure	___	___
Lazy Eye	___	___	Diabetes	___	___	Kidney Disease	___	___
Macular Degeneration	___	___	Emphysema	___	___	Lupus	___	___
Retinal Disease	___	___	Epilepsy/Seizures	___	___	Shingles	___	___
Turned Eye	___	___	Fibromyalgia	___	___	Stroke	___	___
AIDS/HIV+	___	___	Hay Fever	___	___	Thyroid Conditions	___	___
Arthritis	___	___	Heart Condition	___	___	Tuberculosis	___	___

How long has the child been treated for any of the above conditions? \_\_\_\_\_

Please describe any major surgeries/year performed: \_\_\_\_\_

If child is diabetic: How often do they check their glucose? \_\_\_\_\_ Average glucose level: \_\_\_\_\_ A1C Level: \_\_\_\_\_

**CURRENT MEDICATIONS:**

Include over-the-counter AND prescription drugs:

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**ALLERGIES:**

Include food AND drug allergies:

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