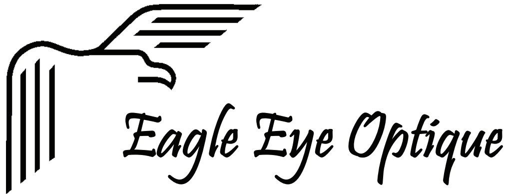

Gary Scearce, OD • 449 E. Summit St • Crown Point, IN 46307

Look Good & See Well

WELCOME TO CHILD OR YOUTH

Today's date _______________ What is the major purpose of this visit? ______________________________

Any problems with your present glasses or contacts? ______________________________

PERSONAL INFORMATION (please print)

Name ______________________________ What do you prefer to be called? ______________

Address ______________________ City ______________ State _______ Zip ________

Birth date ____________ Social Sec. # ______________ Grade in school ____________

Home phone ____________ Parent's Work phone ____________ Cell phone ____________

Email (won't be shared) ______________________________ {Insured's birth date ____________}

Parents' names ______________________________ {Insured member's SSN ____________}

Parent's employer ______________ Vision insur. ______________ Health insur. ______________

Family physician ______________________________ City ______________

MEDICAL HISTORY

- □ Eye injury
- □ Eye surgery
- □ Lazy eye
- □ Cataracts
- □ Glaucoma
- □ Macular degeneration
- □ Retinal detachment
- □ Diabetes
- □ Heart disease
- □ High blood pressure
- □ Skin/ tissue disorder
- □ Arthritis
- □ Nerve disease
- □ Blood disease
- □ Thyroid disease
- □ Ear/ nose/ throat

____

Medications (Rx & OTC) ______________________________

____

____

Allergies ______________________________

FAMILY EYE HEALTH HISTORY

	(*relationship*)
□ Blindness	______________
□ Cataracts	______________
□ Glaucoma	______________
□ Macular degen.	______________
□ Diabetes	______________
□ ______________	______________

DO YOU ………..

- □ work at a computer for long periods?
- □ have more than one pair of glasses? (Backup glasses)
- □ spend time outdoors? (How much? _______ hrs/week)
- □ have prescription sunglasses?
- □ have problems with glare, especially while night driving?
- □ have any interest in refractive surgery?
- □ have any interest in contact lenses?
- □ wear/ have you worn contact lenses?
  What kind/ brand? ______________________
- □ have family members in need of eyecare?

DO YOU EXPERIENCE….

- □ blurry distance vision
- □ blurry near vision
- □ eye strain
- □ headaches
- □ double vision
- □ trouble seeing @ night
- □ sensitivity to light
- □ glare or reflections
- □ uncomfortable glasses
- □ uncomfortable contacts
- □ ______________________
- □ itching eyes
- □ burning
- □ excessive tearing
- □ gritty feeling
- □ dry eyes
- □ discharge/ goopy eyes
- □ crusty eyelids
- □ sudden loss of vision
- □ spots or floaters
- □ flashes of light
- □ nausea
- □ ______________________

How did you first hear about our office? □ Referred by friend or relative? Who can we thank? ______________________
□ Another healthcare provider □ Vision insurance plan □ Internet □ Yellow pages □ other ______________________

How will you settle your account today? □ cash □ credit card □debit card □ check

Payment for services is expected at the time of service. Materials may be ordered with half down and balance on pickup. We will file your insurance as a service but the final responsibility rests with you. A service fee will be charged for non-sufficient funds checks. Should a collection agency be necessary, then collection fees will be added. We do not bill non-custodial parents.

I agree to these terms (parent/guardian signature) ______________________________