Welcome to Radiant Family Eyecare

Child Form (Please Print)

Date_____/_____/_____

Name _____

Address _____

City_____State _____Zip _____

Home phone (_____)_____- _____

Cell phone (_____)_____- _____

Date of last eye exam_____

Father _____

Father's Social Security #_____-_____- _____

Father's Date of Birth_____/_____/_____

Father's Employer _____

Work phone (_____)_____- _____

Cell phone (_____)_____- _____

Gender: M F **Date of Birth** _____/_____/_____

Email Address _____

*****Referred by** _____

Emergency Contact_____

Phone # (_____)_____- _____

Relationship_____

Who performed last eye exam? _____

Mother _____

Mother's Social Security #_____-_____- _____

Mother's Date of Birth_____/_____/_____

Mother's Employer _____

Work phone (_____)_____- _____

Cell phone (_____)_____- _____

Who is responsible for payment? **Father** **Mother** **Other** _____

Insurance Information

Vision Insurance _____

Primary Member _____

Medical Insurance_____

Primary Member _____

To better serve you, all insurance claims will be processed

immediately with the insurance information provided at the time of the appointment.

AUTHORIZATION TO RELEASE INFORMATION TO YOUR INSURANCE COMPANY AND ACKNOWLEDGEMENT OF PERSONAL RESPONSIBILITY FOR PAYMENT

Current Medications

(Rx & Over-the-Counter)

Allergy Meds _____

Blood Pressure Meds_____

Cholesterol Meds _____

Oral Contraceptives _____

Diabetic Meds _____

Eye Drops _____

Other Meds & over-the-counter Meds _____

_____

Allergies To Medications _____

Social History

Do you smoke? Yes No

Are you a former smoker? Yes: Year quit____ No

If yes: Occasionally 1-2pack/wk

3-4 packs/wk 1+ packs/day

Do you drink alcohol? Yes No

If yes: occasionally 1/day 2-3/day 4+/day

Are you currently under the care of a physician? Yes___ No___

Name of physician_____Address_____ Phone #_____

Personal and Family Medical History

	N/A	Self (please list condition)	Family	Relationship
Ear/Nose/Throat:				
Hay Fever	__	__ _____	__	_____
Sinus Congestion	__	__ _____	__	_____
Other	__	__ _____	__	_____
Cardiovascular:				
Heart Disease	__	__ _____	__	_____
High Blood pressure	__	__ _____	__	_____
High Cholesterol	__	__ _____	__	_____
Other	__	__ _____	__	_____
Respiratory:				
Asthma	__	__ _____	__	_____
Other	__	__ _____	__	_____
Gastrointestinal				
Irritable Bowel	__	__ _____	__	_____
Other	__	__ _____	__	_____
Genitourinary:				
Kidney Problems	__	__ _____	__	_____
Other	__	__ _____	__	_____
Musculoskeletal:				
Arthritis	__	__ _____	__	_____
Other	__	__ _____	__	_____
Integumentary:				
Skin Disorder	__	__ _____	__	_____
Neurological:				
Headaches	__	__ _____	__	_____
Migraines	__	__ _____	__	_____
Seizures	__	__ _____	__	_____
Stroke	__	__ _____	__	_____
Other	__	__ _____	__	_____