

Welcome to Radiant Family Eyecare

Child Form (Please Print)

Date ____/____/____

Gender: M F Date of Birth ____/____/____

Name _____

Email Address _____

Address _____

***Referred by _____

City _____ State _____ Zip _____

Emergency Contact _____

Home phone (____) _____ - _____

Phone # (____) _____ - _____

Cell phone (____) _____ - _____

Relationship _____

Date of last eye exam _____

Who performed last eye exam? _____

Father _____

Mother _____

Father's Social Security # _____ - _____ - _____

Mother's Social Security # _____ - _____ - _____

Father's Date of Birth ____/____/____

Mother's Date of Birth ____/____/____

Father's Employer _____

Mother's Employer _____

Work phone (____) _____ - _____

Work phone (____) _____ - _____

Cell phone (____) _____ - _____

Cell phone (____) _____ - _____

Who is responsible for payment? Father Mother Other _____

Are you diagnosed as Diabetic/Pre-diabetic? Yes No If Yes: A1C _____ Type 1 Type 2

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

I hereby assign all medical and/or surgical benefits (to which I am entitled) to the doctor caring for me. This includes major medical benefits, Medicare, private insurance and any health plans in which I am enrolled. This assignment will remain in effect until revoked by me in writing. **I understand that I am financially responsible for all charges whether or not they are paid by my insurance.** I hereby authorize the holder of my medical and patient registration records to release any information needed to process my insurance claims.

Authorized Signature _____ Date _____

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
Eye Conditions:				
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Personal and Family Medical History

	N/A	Self (please list condition)	Family	Relationship
Ear/Nose/Throat:				
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular:				
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory:				
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal				
Irritable Bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary:				
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal:				
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Integumentary:				
Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological:				
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric:				
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alzheimer's/Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine:				
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymphatic:				
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies:				
Seasonal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
General:				
Cancer (type and date Dx)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Reviewed: Date: _____ Patient Initials: _____ Doctor: _____
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