VISION SOURCE
CENTERTON FAMILY EYECARE

Pediatric VISION Development Center

101 Dawn Drive, Centerton, AR 72719 ● 479-795-1411
900 South 52nd St. Suite 102, Rogers, AR 72758 ● 479-657-6006

Personal Information

Patient Name _____ Nickname _____

DOB _____ SSN _____

Address _____ City _____ State _____ Zip _____

Phone # _____ E-mail Address _____

Preferred Contact Person (If Not Patient) _____

Relationship to Patient: _____ Phone# _____

Secondary Contact Person: (Optional) _____

Relationship to Patient: _____ Phone# _____

Health and Vision Insurance Information

Vision Insurance name: _____ ID #: _____

Guarantor: _____ DOB: _____ SSN: _____

Place of employment: _____ Group #: _____

Medical Insurance name: _____ ID #: _____

Guarantor: _____ DOB: _____ SSN: _____

Place of employment: _____ Group #: _____

Payment Information

"I understand that full payment is expected at time of service. I agree that I will pay for all billed services and materials, unless other arrangements have been made with CFE/PVDC. If I have an insurance for which CFE/PVDC is not a panel provider, I will pay the entire amount. I understand that returned checks are subject to a $25.00 charge"

Patient/Guardian signature _____ Date _____

Visual History

Date of last eye exam _____ Optometrist or Ophthalmologist: _____

Reason for today's exam _____

Do you currently wear (Circle) contacts or glasses?

Do you wear them full time? ❑ Yes ❑ No If not full time, for what activities? _____

Who referred you to our clinic/recommended an eye exam? _____

Please check any that apply:

❑ Blur at Distance/Near (please circle)
❑ Headaches: Constant/Frequently/Occasionally
❑ Double Vison
❑ Eye Turn
❑ Dizziness/ Neasuea/Vomiting (please circle)
❑ Loss of Vision
❑ Flashes or Floaters
❑ Light Sensitivity
❑ Squinting or eye rubbing
❑ Vision worse at end of day
❑ Avoid reading
❑ Words moving or swimming on page
❑ Eyes tired or sleepy when reading
❑ Skip lines or lose place while reading
❑ Takes Longer to finish homework or reading
❑ Visual Discomfort (please circle)
At Grocery Store/Driving

Medical History

Patient	Family		Patient	Family
❑	❑	Birth Defects: _____	❑	❑ Autism
❑	❑	ADD/ADHD (circle one)	❑	❑ Learning Disabilities
❑	❑	Developmental Issues	❑	❑ Sensory Processing Disorder
❑	❑	Other (_____)		

Primary Dr. _____ Date of last physical_____

Has the patient ever been in the hospital or had surgery? ❑ Yes ❑ No If yes, explain:

_____

Is the patient currently under a doctor's care? ❑ Yes ❑ No If yes, explain:

_____

Does the patient have a history of medical allergies? ❑ Yes ❑ No If yes, explain:

_____

Please list current medications:_____

_____

Pediatric Patients:

Were there any problems during the pregnancy or birth of your child? ❑ Yes ❑ No ❑ Adopted

If yes, explain: _____

Your child was delivered: ❑ On time ❑ Late ❑ Early Birth weight: ___ / ___ APGAR scores: ___ /____

Does your child have a history of ear infections? ❑ Yes ❑ No

If yes, explain: _____

Any illness with a high fever (temperature of 104^{o} or more)? ❑ Yes ❑ No

If yes, explain: _____

School Information

School _____ Grade _____

Name of Teacher _____

Age entering kindergarten: (years and months) _____

Has your child repeated any grade? ❑ Yes ❑ No Skipped any grade? ❑ Yes ❑ No

Does your child enjoy school? ❑ Yes ❑ No Enjoy reading for fun? ❑ Yes ❑ No

Easier Subjects: ❑ Reading ❑ Spelling ❑ Writing ❑ Math

Harder Subjects: ❑ Reading ❑ Spelling ❑ Writing ❑ Math

Has your child ever had: Educational testing ❑ Yes ❑ No Non-routine medical testing ❑ Yes ❑ No

If yes, please explain: _____

Does your child have an IEP or 504 Plan? ❑ Yes ❑ No For: _____

If no IEP or 504 plan, Currently receives special help/tutoring for: _____

Additional Therapies

Has the patient worked with any of the following: (List name of individual, clinic name, phone number/address. Current or completed)

Occupational Therapist:_____ Physical Therapist: _____

_____ _____

_____ _____

Speech Therapist:_____ Psychologist: _____

_____ _____

_____ _____

Other Specialist: _____