*Simpson and Mann Optometry*

1131 W. Sixth St., Suite 150

Ontario, CA 91762

909-986-0918

FAX 909-984-4918

**Infant and Preschool Child Patient Information Form**

DATE OF EXAM ________________

M/F
_______________________________________________________________________________
Last Name First Name Nickname Birth Date Age

( )
_______________________________________________________________________________
Home Address City State Zip Home Phone Social Security #

( )
_______________________________________________________________________________
Mom's First and Last Name Occupation Work Phone Social Security #

( )
_______________________________________________________________________________
Dad's First and Last Name Occupation Work Phone Social Security #

_______________________________________________________________________________
Names and Ages of Family Members Living at Home

_______________________________________________________________________________
Referred By Physician's Name and Phone

Insurance:

Vision: VSP______ MES____ Other__________________________ Insured By: Mother _____ Father _________

Major Medical: AETNA ____ MEDI-CAL ____ Healthy Families ____ Other ____________ Insured By: Mother _____ Father ____

Patient History:

1. Main Reason for Exam:

____No Problem-General Check Up ____Rubs Eyes Excessively ____ Squint Eyes

____Eyes Turn In ____Eyes Tear Excessively ____Eye or Head Injury ____

____Eyes Turn Out ____2nd Opinion ___ Doctor Referred

____Red/Crusty Eyes ____Visual Problems in Other Family Members

____Blurred Vision

____Other: _______________________________________________________________

2. My Child Is: ___Natural ___ Adopted ___Foster ___ Other

3. Pregnancy History:

a. Length of Pregnancy: ____Less Than 7 mos. ____ 7-8 mos. ____8-9 mos. ___ Over 9 mos.

b. During pregnancy of this child, which, if any of the following occurred:

___ Toxemia ___ Injury by Fall ____ Severe Illness ____Trauma

___ Smoking ___ Prescribed Medication ____ Use of Alcohol ____ Use of Drugs

___ Little Obstetrical Care

Please explain:________________________________________________________________________________

______________________________________________________________________________________________

c. Type of Delivery: ____ Natural ____ Caesarian ____Forceps/Vacuum ____ Anesthesia _____ Other

d. Were there any problems during the delivery? ___No ____ If Yes/Please Explain ________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

4. Child's Birth Weight: ___Lbs. ___Ozs.

5. Is your child currently taking any medications? __Yes __No If "Yes", please list and note purpose: _________________
______________________________________________________________________________________________

6. History of: (please note when or to what)

___High fever ____Ear infections ___Epilepsy or seizures ___ Medication allergies ___ Allergies

**PLEASE TURN OVER**

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7. Patient eye history:

   a. Glasses ___No ___Yes, at age _____Compliance? ______________________________________

   b. Patching ___No ___Yes, at age _____Compliance? ______________________________________

   c. Vision Therapy ___No ___Yes, at age _____Compliance? ______________________________________

   d. Eye Surgery ___No ___Yes, at age _____Compliance? ______________________________________

8. Has any blood relative had: (list relationship to child):

| | | | | | |
|---|---|---|---|---|---|
| ___No | ___Yes | Macular Degeneration | ___No | ___Yes | Heart Disease |
| ___No | ___Yes | Cataracts | ___No | ___Yes | High Blood Pressure |
| ___No | ___Yes | Diabetes | ___No | ___Yes | Retinal Problems |
| ___No | ___Yes | Glaucoma | ___No | ___Yes | Eye Turn |
| ___No | ___Yes | Lazy Eye | ___No | ___Yes | Learning Disability |

9. Developmental Stages

| | ACTIVITY | AVERAGE AGE | EARLY | LATE | NORMAL | UNSURE |
|---|---|---|---|---|---|---|
| a. | Eye control 180 degrees | 3 months | ______ | _____ | ________ | ________ |
| b. | Head Control | 3 months | ______ | _____ | ________ | ________ |
| c. | Hand Grasp | 4 months | ______ | _____ | ________ | ________ |
| d. | Sits w/Out Support | 6.5 months | ______ | _____ | ________ | ________ |
| e. | Walks Unaided | 12 months | ______ | _____ | ________ | ________ |
| f. | Scribbles Spontaneously | 15 months | ______ | _____ | ________ | ________ |
| g. | Combines 2 Different Words | 21 months | ______ | _____ | ________ | ________ |
| h. | Copies Circle | 3 years | ______ | _____ | ________ | ________ |
| i. | Rides Tricycle | 3 years | ______ | _____ | ________ | ________ |

j. Knows Colors 4 years _____ ____ _______ _______

10. List all previous evaluation done on your child:

| DOCTOR OR INSTTITUTION | DATE(S) | TYPE OF EVALUATION | RESULTS/TREATMENT/INTERVENTION |
|---|---|---|---|
| _______________ | ________ | _______________________ | __________________________________ |
| _______________ | ________ | _______________________ | __________________________________ |
| _______________ | ________ | _______________________ | __________________________________ |

11. Names and addresses of individuals or agencies that you wish to receive the results of our exam:

a. ____________________________________________________________

b. ____________________________________________________________

c. ____________________________________________________________

Further Comments:

____________________________________________________________

____________________________________________________________

PAYMENT TERMS: We are happy to assist you in the filing of your insurance claim. If your insurance will not pay the anticipated amount, or your insurance pays you directly, we ask that you pay the balance. Office policy calls for payment at the time of service. If eyewear or contact lenses are to be ordered, a minimum 50% deposit is requested and the balance is due upon delivery. We accept cash, personal checks, Visa and Mastercard. A monthly rebilling fee of $5 is added to all accounts with unpaid balances after 30 days.

I have read and agree to all the provisions of the office financial policy

I have received/reviewed a copy of the health care information privacy policy for Simpson and Mann Optometry

Signature________________________________________ Relation to Child __________________ Date __________

**Thank You**