

# children's eye care, p.c.

Pediatric Ophthalmology & Adult Strabismus

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## PATIENT INFORMATION

### CHILD

Name \_\_\_\_\_ Sex ( ) Male ( ) Female  
Address \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
\_\_\_\_\_  
Social Security No. \_\_\_\_\_  
\_\_\_\_\_  
Zip Code \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

### FATHER

Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Address \_\_\_\_\_ Social Security No. \_\_\_\_\_  
\_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_  
\_\_\_\_\_  
Zip Code \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
Employer \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ Zip Code \_\_\_\_\_

### MOTHER

Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Address \_\_\_\_\_ Social Security No. \_\_\_\_\_  
\_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_  
\_\_\_\_\_  
Zip Code \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
Employer \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ Zip Code \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

### CHILD'S INSURANCE

PRIMARY Insurance \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ Zip Code \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_ Policy Number \_\_\_\_\_  
Secondary Insurance \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ Zip Code \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_ Policy Number \_\_\_\_\_

I hereby authorize and direct my insurance carrier to pay Children's Eye Care, P.C., as appropriate, any benefits due under my insurance plan. I agree to pay any remaining balance or expenses not covered under my insurance plan. I authorize the release of any medical information needed to process the claim. I further permit a copy of this authorization to be used in place of the original.

\_\_\_\_\_ Date \_\_\_\_\_

**Main Office**  
366 Colt Highway, Route 6  
Farmington, CT 06032-2547  
**860-409-0449**

**Glastonbury Professional Center**  
131 New London Turnpike, Suite 200  
Glastonbury, CT 06033-2246  
**860-657-8400**

**Appointments: 860-409-0449**  
**Central Fax: 860-409-0551**  
www.childrenseyecarepc.com  
www.weseekids.com



**CHILDREN'S EYE CARE, P.C.**  
**MEDICAL HISTORY QUESTIONNAIRE—PEDIATRIC**

*We need you to complete this form for your child before we begin the eye exam. Please answer the following questions with explanations as necessary.*

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ ( )M ( )F

Name of Primary Care Physician \_\_\_\_\_ Physician Phone ( ) -

Physician Address \_\_\_\_\_

Did your physician refer you? ( )Y ( )N If not, who gave you our name? \_\_\_\_\_

List others who you would like to receive the results from this exam \_\_\_\_\_

**WHAT COMPLAINT OR OBSERVATION LED YOU TO COME FOR AN EXAMINATION?** \_\_\_\_\_

List all medications your child currently takes \_\_\_\_\_

Does your child have any allergies to any medications ( )Y ( )N Please list: \_\_\_\_\_

List your child's significant medical issues or illnesses \_\_\_\_\_

List all hospitalizations or surgeries \_\_\_\_\_

**REVIEW OF SYSTEMS**

*Does your child currently have any problems in the following areas?*

**EXPLANATION OF PROBLEM**

**GENERAL HEALTH**

Premature birth	( )Y ( )N	Weeks premature _____ Birth weight _____
Birth defect or genetic disorder	( )Y ( )N	_____
Developmental delay	( )Y ( )N	_____
ADD/ADHD	( )Y ( )N	_____
Learning or reading disability	( )Y ( )N	_____

**EYES**

Trouble with a vision screening	( )Y ( )N	_____
Blurry vision—distant or near	( )Y ( )N	_____
Does your child wear glasses?	( )Y ( )N	For how long? _____ How old is the current prescription? _____
Does your child wear contacts?	( )Y ( )N	For how long? _____ How old are the current lenses? _____
Misaligned eyes (strabismus)	( )Y ( )N	_____
Lazy eye (amblyopia)	( )Y ( )N	_____
Double Vision	( )Y ( )N	_____
Head tilt or turn	( )Y ( )N	_____
Closing or covering one eye	( )Y ( )N	_____
Droopy lid or lids (ptosis)	( )Y ( )N	_____
Excessive tearing or discharge	( )Y ( )N	_____
Eye redness	( )Y ( )N	_____
Itching or eye irritation	( )Y ( )N	_____
Color vision problems	( )Y ( )N	_____
Styes or chalazions	( )Y ( )N	_____

**PLEASE CONTINUE ON NEXT PAGE**

