Patient Information Form

Name _____ Gender M F DOB _____

Address _____

City _____ Zip_____

Home Phone _____ Cell Phone _____

Email _____@_____

Marital Status_____ Occupation _____ SSN _____

Referred By _____

Name of Primary Medical Insurance _____

Name of Primary Vision Insurance _____

Primary Policy Holder's Name _____DOB _____ Last 4 of SSN _____

Name of Person to Be Billed (if different from patient) _____

I, the undersigned, give my authorization to treat and assign directly to Lyons Family Eye Care all medical benefits, if any, otherwise payable for me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize Lyons Family Eye Care to use and disclose my health information for purposes of treating me, obtaining payment of services rendered to me and conduction healthcare operations.

Signature _____ Date _____

InfantSEE Medical History

Check any of the boxes that apply:

Have you ever noticed your any of the following happening with your baby's eyes?
☐ Turn in ☐ Turn out ☐ Watering ☐ Have swelling ☐ White appearance in pupil

Explain any eye concerns noted by observing the child: _____
_____

Length of pregnancy: ☐ 36 weeks or more ☐ Less than 36 weeks
☐ Uncomplicated Mothers complications_____
Baby's complications _____
Oxygen used? ☐ Yes ☐ No APGAR Score _____
Delivery complications? ☐ Yes ☐ No Birth Weight _____

List any delivery complications: _____
_____

Child's Doctor's Name: _____
Last Exam Date:

Are immunizations up to date? ☐ Yes ☐ No
Does your baby have any known food or drug allergies? ☐ Yes ☐ No List:_____
List ALL medications taken regularly: ☐ None List: _____

Check all of the following that your baby can do at this time:
☐ Roll Over ☐ Sit ☐ Crawl ☐ Stand ☐ Walk

List any complications of development: _____

Has your baby ever had a high temperature (fever)? ☐ Yes ☐ No
Does your baby suffer from colic? ☐ Yes ☐ No
Has your baby ever had tubes in the ears? ☐ Yes ☐ No

Please list any childhood illnesses, accidents, eye, or head injuries your baby has had:
_____
_____

Indicate immediate family members with any of the following eye or health disorders and their relation to you:

Glaucoma: _____ High Blood Pressure: _____
Macular Degeneration: _____ Diabetes: _____
Cataract: _____ Cancer: _____
Other eye disorders: _____ Other health disorders: _____

Please list anything else we should know about child health:
_____
_____
_____