ANTELOPE VALLEY FAMILY OPTOMETRY
Commitment to eyecare excellence since 1988

INFANT PATIENT INFORMATION

Under 4 years old

Date:_____

PATIENT'S NAME (Last, First, Middle)	□ Male □ Female	BIRTHDATE (m/d/y) / /
HOME ADDRESS	CITY STATE ZIP	
HOME PHONE WORK CELL	SOCIAL SECURITY # - -	
PARENT(S) or GUARDIAN(S):	MEDICAL INSURANCE NAME and # □ PPO □ HMO	
ADULT(S) OCCUPATION:	EMAIL You prefer we notify you via email? Or cell phone via text? □ Yes / No □ Yes / No	

EYE HISTORY Please check all that apply

Have you ever noticed any of the following happening with your baby's eyes?

□ Eye turn □ Eyes red □ Eyes watering □ Itchy □ Swelling around the eyes □ White appearance in pupil □ In □ Out

Any eye concerns noted by observing child?_____

Developmental and Health History

PREGNANCY

Length of pregnancy:_____weeks List any complications during pregnancy: _____

Other pregnancy issues:_____

DELIVERY

Birth Weight:_____ Parents ages at time of birth: Mother_____Father_____

List any complications during delivery:_____

Was oxygen used? □ Yes □ No APGAR score at birth:_____(if known)

MEDICAL HISTORY Check all that apply

CHILD'S DOCTOR:_____ Last Exam Date:_____

Immunizations up to date? □ Yes □ No

Does your baby have any known food or drug allergies?

List ALL medications taken regularly: □ None List:_____

List any developmental delays: _____

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

FAMILY HISTORY

Do any family members have the following:

□ Blindness □ Retinal Disease

□ Eye turn (strabismus) □ Tumor

□ Glaucoma □ Cancer

□ Macular Degeneration □ Other_____

I acknowledge that this information is accurate to the extent that I can be certain, and will disclose more information as necessary. This information can only be used in the management of my child's eyes and vision. Thank you for completing this confidential questionnaire. This will contribute to the understanding of infant eye and vision development.

ACKNOWLEDGEMENT OF RECEIPT ***(Please sign both lines below)***

I acknowledge that I received a copy of Drs. Lin and Quach, O.D.'s Notice of Privacy Practices.

SIGNATURE:_____ Date:_____

Signature of parent

All fees are due at the time service is rendered. We'll be happy to assist you in completing your insurance forms however, the patient is responsible for all fees incurred. I authorize release of info to all my Insurance Companies.

SIGNATURE:_____ Date:_____

Signature of parent NEW REVIEWED DATE: /