School-Aged History

Dr. Jeffrey K. Hollingsworth, O.D.

Personal Information

Patient Name: (Last, First)		**Birth Date:**	**Age:**	**Sex: ❑Male ❑Female**
Address:	**Apt. #**	**City:**	**St:**	**Zip Code:**
Grade:	**School:**	**HM Phone: ( )**		
Name of Parent:		**Email:**		

Medical & Visual History

What is the primary reason for today's visit? (check all that apply) ❑**Annual (Glasses) Exam** ❑**Contact Lens Exam** ❑ **Treatment Visit** ❑ **School recommended exam** ❑**Other:**

When was your last Eye Exam?	**Who was your Eye Dr.?**

List Current Medications:

Please indicate which of the following problems are present. (Check all that apply)

Eye Surgery or Injury	☐	Tilts or turns head while reading	☐
Blurred vision far away	☐	Avoids close work	☐
Blurred vision up close	☐	Frequently reverses letters (p/q, b/d, saw/was)	☐
Frequent loss of place when reading	☐	Rubs eyes frequently	☐
Headaches when reading	☐	Squints with visual tasks	☐
Poor reading comprehension	☐	One eye turns in or out	☐
		Drug Reactions (Please Name)	
		Other:	

Is his or her school performance up to potential? ❑**Yes** ❑**No**
Are you interested in **Contact Lenses** if you are not currently wearing them**?** ❑**Yes** ❑**No**
Hobbies or Activities:_____
❑Computer use:_____hrs./day Other Concerns:

How did you find out about our office?

❑Location ❑I've been here before ❑Yellow Pages ❑Insurance Company
❑Whom may we thank for referring you to us?: _____
Please list any family members who are current patients of Dr. Hollingsworth: _____

I, the patient or guardian, understand that all payments are due at the time services are rendered. I am responsible for all outstanding balances. If I am using insurance, I am responsible for understanding my benefits and for providing full payment in the event my insurance company does not remit full payment, under any circumstance, within 60 days. All insurances must be authorized before the exam. This office is *not* affiliated with Wal-mart so insurance plans differ. All delinquent accounts will be sent to our collection agency for recovery. We recognize that patients may need to cancel or change an appointment but request that they provide at least 24 hours notice. A $25 no show fee will apply to all future missed exams if 24 hours notice is not given.

Please select a desired form of payment: Cash Check MasterCard Visa Discover

I have read, understand and agree to the above Financial Policy.
Patient (or Guardian) Signature _____ **Date** _____

We thank you for selecting us to service your eye care needs.