Drs. Sherman, Taylor & Bisotti

Keith T. Sherman, O.D. — Gregory E. Taylor, O.D. — Anthony J. Bisotti, O.D.

Pre-HIGHSCHOOL PATIENT REGISTRATION

NAME_____

HEAD OF HOUSEHOLD_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

DATE OF BIRTH_____/_____/_____ AGE_____

SCHOOL YOU ATTEND_____

TELEPHONE NUMBER: _____

PARENTS WORK NUMBER: _____

OFFICE POLICIES

Fees will be charged in relation to services rendered. We accept payment from several insurance companies for routine vision services and most insurance companies for medical eye problems. A deposit of approximately 50% is required before eye wear will be ordered, with the balance due at the time of dispensing. Special terms will be made for contact lenses and other terms shoud be discussed prior to orders.

Sign here_____

CIRCLE THE METHOD(s) OF PAYMENT YOU WILL BE USING

CASH CHECK INSURANCE MEDICARE LION'S CLUB

VISA/MASTERCARD/DISCOVER KENTUCKY MEDICAL CARD

Please finish the other side and return it to the receptionist.

Revised 5/6/2011

CHILDREN'S Pre- High School HISTORY FORM

Approximate date of the last eye examination __/__/__ Today's Date __/__/__

Why do you or your parents feel we should check your eyes today?_____

_____

Do you wear glasses? Y N Contact Lenses? Y N

Check or Circle all of the following eye conditions you now have or have had.

ITCHING	GLAUCOMA	HALOS AROUND LIGHTS	BLURRED VISION
BURNING	CATARACTS	CROSSED EYE	PAIN IN EYE
TEARING	EYE DISEASE	LAZY EYE	LOSS OF SIGHT
RED EYES	EYE SURGERY	COLOR VISION PROBLEM	SEEING DOUBLE
INFECTION	EYE INJURY	FLASHES OF LIGHT	OTHER _____

Do you use drops or medicines in your eyes? Y N

Where do you sit in the class room? FRONT BACK MIDDLE

Do you like school? Y N What grade are you in? _____

Do you have problems seeing the board? Y N

What is your favorite class or subject?_____

Do you like to read? Y N

Do your eyes bother you when you read? Y N

Who is your family medical doctor? _____

List all pills, tablets or other medication you regular take? _____

_____

List all medication you are ALLERGIC to. _____

Check or Circle any of the following eye conditions that your blood relatives have had.

GLAUCOMA TURNED OR CROSSED EYE LAZY EYE OR AMBLYOPIA

What hobbies, sports or recreational activities do yo enjoy? _____

_____