Drs. Sherman, Taylor & Bisotti

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

Pre-SCHOOL PATIENT REGISTRATION

NAME_____

HEAD OF HOUSEHOLD_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

DATE OF BIRTH_____/_____/_____ AGE_____

SCHOOL YOU WILL 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 PRESCHOOL HISTORY FORM

Is this your child's first eye examination by an eye doctor? NO YES Today's Date ___/___/___

What is the main reason you want to have your child's eyes checked today? _____

Is this child yours by: BIRTH ADOPTION STEPCHILD OTHER? _____

If you are the birth mother, did you have any medical problems during pregnancy? NONE YES

Explain _____

Was the child born prematurely? NO YES Birth weight of child _____

Have you noticed any developmental delays with your child? NO YES, explain _____

_____

Does you child wear glasses? Y N

Check or Circle all of the following eye conditions that your child has experienced or complained about:

ITCHING	CROSSED EYE	BLURRED VISION	SEEING DOUBLE
BURNING	CATARACTS	PAIN IN EYE	EYE INJURY
TEARING	EYE DISEASE	LAZY EYE	INFECTION
RED EYES	EYE SURGERY		OTHER _____

Does your child use drops or medicines in their eyes? NO YES _____

Who is your child's family medical doctor? _____

List all pills, tablets or other medication your child takes daily? _____

_____

List all medication your child has had an ALLERGIC reaction to: _____

Describe any medical problems or hospitalizations your child has experienced: _____

_____

Check or Circle any of the following eye conditions that your child's blood relatives have had:

GLAUCOMA TURNED OR CROSSED EYE LAZY EYE OR AMBLYOPIA

What activities does your child seem to enjoy? _____

_____