

Kentucky Pediatric Ophthalmology & Strabismus (KPOS) New Patient Registration Form - Child

(Please print and complete both sides of this form)

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Age: _____ Sex: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Mother's Name: _____ Phone: _____

Father's Name: _____ Phone: _____

REFERRING & PRIMARY CARE PHYSICIAN INFORMATION

Referring Physician's Name: _____ Phone: _____

Primary Care Physician's Name: _____ Phone: _____

INSURANCE GUARANTOR'S INFORMATION (the person who carries the insurance)

Guarantor's Name: _____ SSN: _____

Relationship to patient: _____ DOB: _____

Employer: _____ Phone: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

Contact's Name: _____ Relationship to patient: _____

Home Phone: _____ Work Phone: _____

ACCIDENT INFORMATION

Is this visit accident related? YES NO (If yes, please fill out below)

Date of Accident: _____ Time of Accident: _____ Place of Accident: _____

Nature of Accident: _____

NEW PATIENT QUESTIONS

Does anyone smoke in the house? YES NO

Is the patient having any trouble in school? YES NO

What grade is the patient in? _____

Has the patient had any previous eye problems? _____

Does the patient have a family history of:

(who)

(who)

Crossed Eyes YES NO _____ Eye Surgery YES NO _____

Lazy Eyes YES NO _____ Other Eye Problems YES NO _____

Has the patient had any problems with:

Fever	YES	NO	Stomach or Intestine	YES	NO
Weight Loss	YES	NO	Urinary System or Bladder	YES	NO
Allergies	YES	NO	Joint, Bone, or Muscles	YES	NO
Skin Rash	YES	NO	Glands (endocrine, diabetes or thyroid)	YES	NO
Ear, Nose or Throat	YES	NO	Blood Diseases	YES	NO
Breathing/ Asthma	YES	NO	Growth or Neurologic Dev.	YES	NO
Heart	YES	NO	Emotions or Behavior	YES	NO

PAST MEDICAL HISTORY

Please list all medical problems, major illnesses, hospitalizations, or surgeries:

Please list all medications the patient is currently taking (including eye drops):

Any allergies to medications? YES NO (if YES, please list below)

Reason for today's visit:

Parent/Guardian Signature: _____ Date: _____

Physician's Signature: _____ Date: _____