PEDIATRIC PATIENT INFORMATION Exam Date _____

Lawrence S. Turtel, MD and Ilene B. Pardon, MD

Child's Last Name _____ First Name _____ M.I. ____
Birth date _____ Present Age _____ Male _____ Female _____
Home Address _____ City: _____ State _____ Zip _____
Home Tel. # _____ Cell Phone # _____ Soc. Sec. # _____
Email: _____

Father's Name _____ Mother's Name _____
Soc. Sec. # _____ Soc. Sec. # _____
Employer _____ Employer _____
Work phone (____) _____ Work phone (____) _____
Primary Language: English ___ Other _____ Race _____ Ethnicity _____ Decline Info ___
Person with child today: Mother _____ Father _____ Bro/Sister _____ Guardian _____ Other _____
Is the patient adopted? Yes _____ No _____

Emergency contact person _____ Telephone (____) _____
Primary Insurance Co. _____ ID # _____ Group # _____
Subscriber's Last Name _____ First Name _____ Birth date _____
Subscriber's Social Security # _____ Relationship to Insured _____

Secondary Insurance Co. _____ ID # _____ Group # _____
Subscriber's Last Name _____ First Name _____ Birth date _____
Subscriber's Social Security # _____ Relationship to Insured _____
Motor Vehicle Accident, If Yes, Insurance _____ Claim # _____
Pediatrician: _____ Referring Doc (if different): _____

Reason for visit _____
☐ Right Eye ☐ Left Eye ☐ Both How long? _____

Previous Eye Care
☐ Glasses
☐ Contact Lenses
☐ Patching
☐ Eye Surgery
☐ **None**

Child's Medical History
☐ Asthma
☐ ADD/ADHD
☐ Autism
☐ Cerebral Palsy
☐ Developmental Delay
☐ Diabetes
☐ Down Syndrome
☐ **None**

Family History
☐ Glaucoma
☐ Crossed/Turned Eye
☐ "Lazy" Eye
☐ High Myopia
☐ Decreased Vision
☐ Migraine
☐ **None**

Other: _____

☐ Prematurity, if yes, Birth Weight _____ Weeks Gestation _____
Current Medications: _____
Current Eye Drops: _____
Drug Allergy: _____

Preferred Pharmacy Name and address _____

SIGNATURE _____ Date _____