Sooke Eyecare

Intake Form Child (age 3-16)

Updated Mar 2025

General Information

Child's Name: _____ DOB: _____

Address: _____ Family Doctor: _____

Is this a first eye examination? Yes, ___ No ___ If not, what is the approximate date of the last eye exam: _____

Personal Health Number: _____

Parent/Guardian Contact Information Names of Parents/Guardians: _____

Email Address: _____

Home#_____ Cell#1/Name: _____ Cell#2/Name: _____

Eye Health, Medical Health, Family History

Child's Medical History (current or previous) check all that apply:

No Problems ___ Amblyopia (lazy eye) ___ Diabetes ___ Strabismus (eye turn) ___ Other: _____

List *any* eye surgeries or injuries: _____

List *any* medical conditions: _____

List their current medications: _____

List *any* medicine allergies: _____

List *any* other allergies: _____

List any family eye history(circle): Glaucoma Cataracts Macular Degeneration Lazy Eye Retinal Detachment Iritis/Uveitis

Have they ever had to do Vision Therapy (eye exercises)? Yes ___ No ___

Have they ever had to do any patching (wear a patch over one eye)? Yes ___ No ___

Current Vision & Eye Care Needs

Do they currently wear glasses? Yes ___ No ___

What do they use their glasses for? Distance ___ Reading ___ Computer ___ All the Time ___ N/A ___

What is the **main reason** for your visit: _____

List their sporting activities/hobbies: _____

Do we have your permission to put dilation drops in your child's eyes? Yes ___ No ___

- **CONSENT FOR TREATMENT**: I/We hereby authorize Sooke Eyecare to administer diagnostic and medical procedures as may be necessary for proper ocular health care, including dilation drops that may last between 4-24 hours.
- **OFFICE POLICY ON PAYMENT:** I understand that I am responsible for payment of all charges. As a courtesy, my insurance may be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company at the time of billing. I authorize insurance benefits to be paid directly to the provider, if I request it.
- **CONSENT FOR EMAIL COMMUNICATION:** I consent to Sooke Eyecare sending me information about Sooke Eyecare by e-mail and other electronic communications. I understand I can withdraw my consent at any time by contacting Sooke Eyecare at 5-67265 West Coast Rd, Sooke, BC. My email will not be used for marketing unless I request it and will not be provided to a third party.
- **CANCELLATION POLICY:** I agree to provide 24 hours notice for any appointment cancellation. I understand that if I do not, I will be required to pay a rebooking fee before being able to book any household appointments.

- **Parent/Guardian Signature:_____ Date:_____**