LODESTAR
FAMILY EYE CARE, PC

JACOB FRANK, OD | KARA REYNOLDS, OD

GUIDING YOU TO BETTER VISION

Youth Patient Form

Patient Name: _____ Date: _____

Parent/Guardian Name(s): _____

Address: _____ City: _____State: _____Zip: _____

Parent/Guardian Cell Phone: _____ Parent/Guardian Home Phone: _____

Parent/Guardian Email: _____
Preferred Method of Contact: ☐Cell Phone ☐ Home Phone ☐Email

Patient's Date of Birth: _____ Grade in School: _____

Name of Person Responsible for Account: _____

Responsible Party's Date of Birth: _____ Responsible Party's Social Security Number: _____

Occupation: _____ Name of Employer: _____

Please list any family members of your household who come to our office.

_____

Who referred you to our office?
Insurance Listing ☐ Family Member ☐ Physician/Eye Doctor ☐Website ☐Facebook ☐ Passed by Office
☐ Previous Patient of Dr. Frank ☐ Dr. Reynolds ☐ Friend/Family Member – Name: _____

Please list any eye problems, medical problems or learning/developmental problems this patient has.

_____

Any difficulties at school? _____

Patient's Primary Care Doctor? _____ Date of last exam/visit: _____

Please list current medications and/or supplements:

_____

Is the patient allergic to any medications? ☐ Yes ☐ No Please List: _____

Previous Eye Doctor: _____ Last Eye Exam: _____

Have any bloodline relatives had glaucoma, macular degeneration or other loss of sight? ☐ Yes ☐ No

Does the patient presently wear glasses? ☐ Yes ☐ No If yes, how old are the glasses? _____

When do they wear them? _____

Does the patient presently wear contact lenses? ☐ Yes ☐ No
What type? ☐ Soft Disposable ☐ Hard ☐ Gas Permeable ☐ Other

If yes, how old are the contacts? _____ If no, have they ever worn contact lenses? ☐ Yes ☐ No

Does the patient have vision care benefits? ☐ Yes ☐ No
If yes, what company and ID number: _____

Does the patient have medical health insurance? ☐ Yes ☐ No
If yes, what company name and ID number: _____

Parent or Guardian Signature: _____