



PATIENT INFORMATION

PLEASE PRINT

DATE: ____ / ____ / ____

NAME: _____
Last First M.I.

ADDRESS: _____

City State Zip

DATE OF BIRTH: ____ / ____ / ____

SEX: M F

RESPONSIBLE PARTY INFORMATION

Father's name: _____

HOME PHONE: () - _____

Please check if address is the same as the patient's:

WORK PHONE: () - _____

Address: _____

CELL PHONE: () - _____

City State Zip

EMPLOYER: _____

If applicable: step-mother's name: _____

Mother's name: _____

HOME PHONE: () - _____

Please check if address is the same as the patient's:

WORK PHONE: () - _____

Address: _____

CELL PHONE: () - _____

City State Zip

EMPLOYER: _____

If applicable: step-father's name: _____

MISCELLANEOUS INFORMATION

Please Read:

**I understand that today's appointment is for a vision screening only.
It does not take the place of a complete eye exam.**

The screening is meant to give parents an indication of possible vision problems which could affect their child's school performance. If areas of concern are indicated, we will discuss the screening results with you and may make a recommendation for a complete eye examination by a credentialed doctor to fully evaluate the area of concern.

Signature

____ / ____ / ____
Date

How did you hear about Wichita Vision Development Center? _____