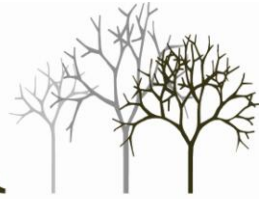


Alderwood



Vision Therapy Center, PLLC

TRANSFORMING LIVES THROUGH VISION

Welcome to our office and thank you for making an appointment for a comprehensive vision examination. On the following pages you will find a Returning Children's Vision Questionnaire and symptom checklist. **Please either return the completed forms to our office before your scheduled appointment, or bring them with you to the examination.**

Thank you again for your cooperation in providing this complete history.
We look forward to seeing you!

16006 Ash Way, Suite 101, Lynnwood, WA 98087
Phone: (425) 787-5200 Fax: (425) 787-5252

Nancy G. Torgerson
Doctor of Optometry

Kristi A. Jensen
Doctor of Optometry

Willow F. Thompson
Doctor of Optometry

DRIVING DIRECTIONS

Alderwood Vision Therapy Center, PLLC
16006 Ash Way, Suite #101
Lynnwood, WA 98087
(425) 787-5200

Southbound on I-5 coming from Everett, WA

1. Take exit #183, towards 164th St. S.W.
2. Keep RIGHT to stay on Ramp
3. Bear RIGHT (West) onto 164th St SW, then immediately turn RIGHT (North) onto Ash Way
4. Our building will be on your left at 16006 Ash Way #101, Lynnwood, WA 98087

Northbound on I-5 coming from Seattle, WA

1. Take exit #183
2. Turn LEFT (West) onto 164th St SW
3. Turn RIGHT (North) onto Ash Way
4. Our building will be on your left at 16006 Ash Way #101, Lynnwood, WA 98087

Northbound on I-405

1. Merge onto **I-5 North**
2. Take exit #183
3. Turn LEFT (West) onto 164th St SW
4. Turn RIGHT (North) onto Ash Way
5. Our building will be on your left at 16006 Ash Way #101, Lynnwood, WA 98087

From the Edmonds Ferry:

Go on road from ferry until you see I-5 North and take that. Then follow the instructions above for Northbound I-5.

Our office is located in a separate building at the north end of Newberry Square.

RETURNING CHILDREN'S VISION QUESTIONNAIRE

Appointment: Day _____ Date _____ Time _____

Patient's Name: _____

Patient's Nickname: _____

GENERAL INFORMATION

Were you referred to our office? Yes No

If yes, whom may we thank for this referral? _____ Phone: _____

Address: _____ Profession: _____

Child's Full Legal Name: _____ Male _____ Female _____

Birth Date: _____ Age: _____ years _____ months

Home Address: _____

City: _____ Zip: _____ Home Phone: _____

Name and address of school: _____

Grade: _____ Teacher: _____

Child's dominant hand (circle): right / left / undetermined?

Please list the names and birth dates of your family:

Father/Caretaker _____ Birth Date _____

Mother/Caretaker _____ Birth Date _____

Sibling _____ Birth Date _____

Sibling _____ Birth Date _____

Sibling _____ Birth Date _____

Sibling _____ Birth Date _____

ACCOUNT RESPONSIBLE INFORMATION

Person Responsible for Account: _____ Relationship to Patient: _____

Account Responsible Address: _____

City: _____ Zip: _____ Home Phone: _____

Father/Caretaker's Occupation: _____ Work Phone: _____

E-mail: _____ Cell Phone: _____

Mother/Caretaker's Occupation: _____ Work Phone: _____

E-mail: _____ Cell Phone: _____

In Case of Emergency Contact: _____ Phone: _____

Do you have Vision Insurance? Yes No If so, who is the carrier? _____

Insurance Address: _____ Insurance Phone: _____

Subscriber Name: _____ DOB: _____ SSN: _____

Subscriber ID# (incl. letter prefix): _____ Group #: _____

Do you have Medical Insurance? Yes No If so, who is the carrier? _____

Insurance Address: _____ Insurance Phone: _____

Subscriber Name: _____ DOB: _____ SSN: _____

Subscriber ID# (incl. letter prefix): _____ Group #: _____

**PLEASE REMEMBER TO BRING YOUR INSURANCE CARD(S)
WITH YOU TO YOUR APPOINTMENT.**

Does your child report any of the following:

	<u>Yes</u>	<u>If yes, when?</u>
Headaches	<input type="checkbox"/>	_____
Blurred vision	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	_____
Eyes hurt	<input type="checkbox"/>	_____
Eyes tired	<input type="checkbox"/>	_____
Words move around on the page	<input type="checkbox"/>	_____
Motion sickness / car sickness	<input type="checkbox"/>	_____
Dizziness	<input type="checkbox"/>	_____
Frequent sties	<input type="checkbox"/>	_____

List any other complaints your child makes concerning his/her vision: _____

Have you or anyone else ever noticed the following:

	<u>Yes</u>	<u>If yes, when?</u>
Moves head when reading	<input type="checkbox"/>	_____
Skips, re-reads or omits words	<input type="checkbox"/>	_____
Loses place while reading	<input type="checkbox"/>	_____
Reads slowly	<input type="checkbox"/>	_____
Uses finger as a marker	<input type="checkbox"/>	_____
Eyes frequently reddened	<input type="checkbox"/>	_____
Frequent eye rubbing	<input type="checkbox"/>	_____
Frowning	<input type="checkbox"/>	_____
Bothered by light	<input type="checkbox"/>	_____
Frequent blinking	<input type="checkbox"/>	_____
Closing or covering one eye	<input type="checkbox"/>	_____
Head close to paper when reading or writing	<input type="checkbox"/>	_____
Focus goes in and out	<input type="checkbox"/>	_____
Avoids reading	<input type="checkbox"/>	_____
Prefers being read to	<input type="checkbox"/>	_____
Tilts head when reading	<input type="checkbox"/>	_____
Tilts head when writing	<input type="checkbox"/>	_____
Confuses letter or words	<input type="checkbox"/>	_____
Reverses letter or words	<input type="checkbox"/>	_____
Difficulty copying from chalkboard	<input type="checkbox"/>	_____
Vocalizes when reading silently	<input type="checkbox"/>	_____
Confuses right and left	<input type="checkbox"/>	_____
Poor reading comprehension	<input type="checkbox"/>	_____
Comprehension decreases over time	<input type="checkbox"/>	_____
Tires easily	<input type="checkbox"/>	_____
Difficulty recognizing same word on different page	<input type="checkbox"/>	_____
Poor word attack skills	<input type="checkbox"/>	_____

Date: _____ Dr's Initials: _____

- Difficulty with memory _____
- Remembers better what hears than sees _____
- Responds better orally than by writing _____
- Seems to know material, but does poorly on tests _____
- Dislikes / avoids near tasks _____
- Short attention span / loses interest _____

- Poor large motor coordination _____
- Poor fine motor coordination _____
- Difficulty with scissors / small hand tools _____
- Dislikes / avoids sports _____
- Difficulty catching / hitting a ball _____
- Writes or prints poorly _____
- Writes neatly but slowly _____
- Does not support paper when writing _____
- Awkward or immature pencil grip _____
- Frequent erases _____

FINANCIAL POLICY

If we are participating providers with your insurance company, we will bill them directly. If we are not, we require payment at the time of the visit and we will provide a receipt for reimbursement submission. Copayment is also required at the time of service.

We are participating providers with:

Blue Cross Blue Shield, Regence Blue Shield, Premera Blue Cross, Medicare, and Medicaid/DSHS (only open coupon and Regence Healthy Options) **We are not providers with any HMO.**

By signing below you authorize the release of any medical information to process your insurance claim or for the referral to another doctor. You also allow your payment from insurance to be sent directly to Alderwood Vision Therapy Center, PLLC.

Please sign that you understand the above:

Signed: _____ **Date:** _____

Nancy G. Torgerson
Doctor of Optometry

Willow F. Thompson
Doctor of Optometry

Kristi A. Jensen
Doctor of Optometry