NGUYEN FAMILY VISION CARE OPTOMETRY CORPORATION
Trang V. Nguyen, O.D., F.A.A.O.
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310 / 449-0066 Fax 310 / 453-2971

Child's Information Sheet

Child's Name _____ Date of Birth _____

Address _____ City/Zip Code_____

Name of School _____ Grade _____

Parent's Name _____ **Phone (please circle one below) (H or C)** _____

Address (if diff't)_____ City/Zip _____

Business Address _____ Work Phone _____

Parent's Name _____ **Phone (please circle one below) (H or C)** _____

Address (if diff't)_____ City/Zip _____

Business Address_____ Work Phone _____

Primary email address for patient portal (system only allows one):_____

Additional parent/guardian emails for reports purposes:_____

What is the reason for the exam? _____

_____

___"Well Check" Eye Examination___Visual Dyslexia/Reading Testing___Visual Perception/Processing Exam

Which of the Following Apply to your Child?

___ Eyes Cross/Turn Outward
___ Blurred Sight
___ Difficulty Copying from Board
___ Smart verbally but poor reading
___ Difficulty keeping place when reading
___ Heart or Cardiovascular Problems
___ Neurological problems/Seizures
___ Respiratory/Breathing Problems
___ Motor or Muscle Problems
___ Speech or Language Problems

What Medications Does Your Child Take?_____

Who Referred You To Our Office?_____

___ I authorize the release of information ___ I do not authorize the release of information

Signature_____ Date _____