

TOD R. DAVIS, O.D.

Developmental Optometry and Vision Therapy Services
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CHILD AND ADULT INFORMATION

Date: _____

Full name: _____

Nickname: _____

Birthdate: ___/___/___ Yrs, ___ Mos

If child, adopted? ___ foster? ___

If child, parents or responsible person's names:

Social Security # (if child, list parent's #) _____

Mailing Address: _____

Home ph # _____

Work ph # _____

Cell # _____

Email _____

If child, names & age(s) of sibling(s): _____

How did you learn about our office?

- Patient referral: who? _____
- Professional referral: who? _____
- Internet Phone book Dr. Davis' Talks
- School/Teacher _____
- Other: _____

If applicable, to whom would you like a report sent:

Email/Address: _____

O.K. to contact child's teacher if applicable?

- YES NO

Signed: _____

HEALTH HISTORY

- Allergy, chronic patient family
- Amblyopia patient family
- Autism patient family
- Asthma patient family
- Blindness patient family
- Cancer patient family
- Cerebral Palsy patient family
- Color blindness patient family
- Developmental Delay patient family
- Dyslexia patient family
- Diabetes patient family
- Ear infections patient family
- Eye turns patient family
- Eye surgeries patient family
- Frequent illnesses patient family
- Glaucoma patient family
- Gluten Sensitivity patient family
- High fevers patient family
- High blood pressure patient family
- Head/neck injury patient family
- Lactose intolerant patient family
- Lazy eye patient family
- Learning Disabilities patient family
- Light sensitive patient family
- Patching of eye patient family
- Respiratory disease patient family
- Seizures patient family
- Strokes patient family
- Other:

Medications: _____

Date & results of last eye exam: _____