EYES ON HENRY

Pediatric History Form

Patient Information

Today's Date _____

Child's Last Name _____
First_____ MI _____
Preferred Name _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____

Parent/Guarantor Name _____
SSN _____
Work Phone _____ Cell Phone _____
Email _____

Child's SSN _____
Date of Birth _____
Sex M F
School _____ Grade _____

What is the major purpose of this visit?

_____

_____

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name of friend or relative _____

If not referred, how did you choose our office?
❑ Another Dr. ❑ Insurance List
❑ Saw Sign/Building ❑ Yellow Pages
❑ Other _____

The mission of this practice is to meet our patients' comprehensive visual and ocular health care needs and exceed their expectations in a friendly, compassionate, and educational atmosphere, nurturing lasting relationships with patients of all ages.

Insurance Information

Vision Insurance _____
Policy/ID Number_____
Group Number _____
Subscriber's Name _____
Subscriber's SSN_____
Subscriber's Birth Date _____
Subscriber's Employer _____

Primary Medical Insurance _____
Policy/ID Number_____
Group Number _____
Subscriber's Name_____
Subscriber's SSN_____
Subscriber's Birth Date _____

Secondary Medical Insurance_____
Policy/ID Number_____
Group Number _____
Subscriber's Name_____
Subscriber's SSN _____
Subscriber's Birth Date _____

Lifestyle Questions

Does your child… (check box if your answer is yes)
❑ spend time on electronic devices?
How many hrs/day? __
❑ complain about glare or light sensitivity?
❑ spend time outdoors? How many hrs/week? ___
❑ have sun wear (prescription and/or non-prescription)?
❑ prefer not to wear your glasses at times?
❑ have a spare pair of glasses in their current Rx?
❑ have family members or friends in need of eye care?

Has your child ever experienced, been diagnosed or treated for any of the following?

❑ Blurry Vision
❑ Sunlight Sensitivity
❑ Trouble seeing at night
❑ Itchiness
❑ Burning
❑ Tearing
❑ Dry Eyes
❑ Flashes of Lights
❑ Eye Infections
❑ Eye Injury
❑ Crossed eye/Eye Turn
❑ Lazy Eye
❑ Double Vision
❑ Other eye disorders_____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Pediatrician _____
Town _____
Date of Last Physical Check-up _____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____
_____
_____

Allergies to any medications? ❑ Yes ❑ No
If so, what medications?_____
_____

Preferred Pharmacy _____
Street _____
City: _____

Has your child had any major surgeries? ❑ Yes ❑ No
Please list _____
_____

Have you ever been diagnosed or treated for the following health problems?

❑ Allergies
❑ Blood/Lymph
❑ Cholesterol
❑ Digestive
❑ Fatigue
❑ Genitourinary
❑ Integumentary (Skin)
❑ Muscle/Bone
❑ Psychological
❑ Thyroid
❑ Arthritis
❑ Cancer
❑ Diabetes
❑ Eczema/Rashes
❑ Fevers
❑ High Blood Pressure
❑ Kidney
❑ Neurological
❑ Respiratory

Patient Eye History

Date of Last Eye Exam_____
By Whom?_____

Does child currently wear contact lenses?
❑ Yes ❑ No
What kind?_____
Solutions used_____

Is your child satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

If you don't wear contacts, would you be interested in being fit for them ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:

	Relationship to your child
Blindness	❑_____
Cataracts	❑_____
Corneal Problems	❑_____
Diabetes	❑_____
Glaucoma	❑_____
Heart Disease	❑_____
Lazy Eye	❑_____
Macular Degeneration	❑_____
Retinal Problems	❑_____

Mother's Pregnancy History (Did any of the following occur?)

❑ Infection
❑ Drug Use
❑ Alcohol use
❑ Premature Delivery
Other _____

Please be advised if you are using insurance coverage for today's visit, we require a valid copy of your insurance card to ensure that your claims are filed properly. We will file your insurance for you as a courtesy, however if your insurance does not cover a particular service, you will be responsible for the balance, any copays, deductibles, and/or contact lens fitting fees. Payment of these is due at the time of the service.

By signing, you authorize your insurance company to make payment to this practice for services and material provided. You authorize the practice to deposit checks received on your account if made out to you, the patient. You authorize the practice to initiate a complaint to the Insurance Commissioner for any reason on your behalf.

Parent/Guarantor Signature_____ Date: _____

Authorization for Release of Information

This form authorizes Eyes on Henry to release protected information about the patient named below to the people listed (e.g. spouse, parent, sibling) by means of phone calls and voice mail/answering machine messages.

I consent to the release of (please check all that apply):
___ Financial/Billing Information
___ Medical Care (treatment plans, medications, procedures, appointments, test results, etc.)

This information may be released to the following:
___ Patient's voice mail/answering machine
___ Voice mail/answering machine of (e.g. spouse, parent, sibling)

_____ _____
Name/Relationship to patient Phone#

_____ _____
Name/Relationship to patient Phone#

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in the document by sending a written notification to Eyes On Henry. I understand a revocation is not effective in cases where the information has already been disclosed.
I understand that information used or disclosed because of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing This authorization shall be in effect until revoked by the patient.

_____
(Signature of Patient (parent or legal guardian if patient is a minor)

Acknowledgement of Notice of Privacy Practices

Eyes on Henry will provide me a copy of their Notice of Privacy Practices up request. _____
(Please initial)