Welcome to **St. Anthony** Eye Clinic | Child Form

Last Name:________________________ First Name:___________________________ Middle Initial: _____ Date of Birth:_____________

Sex: M / F Preferred method of communication ☐Email ☐Text ☐Postcard

Address:____ City:___________________________________

State:___________ Zip:_____________ E-mail Address:____

Home Ph: ( )_________________ Work Ph: ( )_________________ Cell Ph: ( )__________________

Insurance Member Name: _____________________________ Relationship: ______________ Date of Birth: _______________

How did you find out about our office? ____

Please check the correct response:

Preferred Language: ___*English* ___*Spanish* ___*Other*

Ethnicity: ___*Hispanic/Latino* ___*Other*

Race: ___ *Asian* ___*Black/African American* ___*Hispanic*

___*Native American* ___*Pacific Islander* ___*White* ___*Other*

CASE HISTORY:

Date of Latest Eye Exam: ____________ Clinic/Eye Doctor's Name: _____________________________________

Date of Latest Medical Exam: _____________ Primary Physician/Clinic: _________________________________

Does your child currently wear glasses? No / Yes: Full time / Part time / Reading only

Does your child currently wear sunglasses? No / Yes: Prescription / Non-Prescription

Does your child currently wear contact lenses? No / Yes: Soft / Gas Permeable (RGP).

Brand: ________________ Solution Brand: __________________________

If No, are you interested in trying contacts? Yes / No

Has your child had an eye injury? No / Yes: Which Eye? R / L Type of injury: ________________________

Has your child ever had eye surgery? No / Yes: Why? ____

Does your child currently use eye drops? No / Yes: Why?___________________________________

SCHOOL HISTORY:

School:____ School Grade: _________________________________

What subjects does the child consider hardest:_______________________ easiest:____________________________

What are the child's favorite activities: ____

Average time daily spent on a computer: ____________ playing video games:_____________watching TV:__________

Please CIRCLE any CURRENT SYMPTOMS:

Blurred Distance Vision	Blurred Near Vision	Double Vision	Squinting
Eye Strain	Headaches	Eye Pain/Soreness	Tired Eyes
Red Eyes	Itchy Eyes	Light Sensitivity	Eye Turn

MEDICAL HISTORY: CHECK ANY THAT APPLY. If none – CHECK 'None'

Cardiovascular: ___ Heart Disease ___ Stroke ___ High Blood Pressure ___ High Cholesterol ___ Other: ___**None**	**Neurological:** ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Other: ___**None**	**Endocrine:** ___ Diabetes - Non-Insulin Dependent ___ Diabetes - Insulin Dependent ___ Thyroid Condition ___ Hormonal Dysfunction ___ Other: ___**None**	**Respiratory:** ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Other: ___**None**
Psychiatric: ___ ADHD ___ Depression ___ Schizophrenia ___ Other ___**None**	**Ear/Nose/Throat:** ___ Hearing Loss ___ Chronic Sinus Infections ___ Other: ___**None**	**Constitutional:** ___ Cancer ___ Trauma/Large Volume Blood Loss ___ Developmental Disability ___ Other: ___**None**	**Gastrointestinal:** ___ Crohn's ___ Colitis ___ Other: ___**None**
Dermatologic: ___ Eczema ___ Rosacea ___ Psoriasis ___ Other: ___**None**	**Immunologic:** ___ AIDS or HIV ___ Rheumatoid Arthritis ___ Lupus ___ Neurofibromatosis ___ Other ___**None**	**Musculoskeletal:** ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Other: ___**None**	**Hematological:** ___ Anemia ___ Leukemia ___ Other: ___**None**
Allergies to Environmental or Seasonal Causes: Please List – with physical reactions: ___**None**	**Allergies to Medications:** Please List – with physical reactions: ___**None**	**Tobacco Exposure:** **No** **Yes** ___**None**	

Please list any medications, drugs, vitamins, herbals that your child is currently taking:

1 ______________________________ for_____________________ 3 ______________________________ for_____________________

2 ______________________________ for_____________________ 4 ______________________________ for_____________________

FAMILY HISTORY: **Has anyone in your family been diagnosed with these DISEASES or CONDITIONS?**
Who? G = Grandparents, P = Parents, S = Siblings.

High Blood Pressure:	No / Yes ___________	Blindness:	No / Yes ___________
Diabetes:	No / Yes ___________	Cataracts:	No / Yes ___________
Cancer:	No / Yes ___________	Glaucoma:	No / Yes ___________
Heart Disease:	No / Yes ___________	Macular Degeneration:	No / Yes ___________
Retinal Detachment:	No / Yes ___________	Amblyopia/Lazy Eye:	No / Yes ___________
Color Blindness:	No / Yes ___________	Strabismus/Eye Turn:	No / Yes ___________

Note: Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies!!! Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay. ______*initial*

HIPAA Privacy Practices: I acknowledge that I have the option of receiving the St Anthony Eye Clinic Notice of Privacy Practices.

Signature: ____ Date: _____________________

If you are under 18, parental signature is required.

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