DATE	INT.

Medical History Questionnaire
Kid's Eye Site

PATIENT INFORMATION

Name: _____ Today's Date: ___/____/_____
Address: _____ Birth Date: ____/____/_____
City: _____ State: _____ Zip: _____ Gender: (circle) Male Female
Email: _____ Home Phone: _____
Preferred way of contact: (circle) Call Text Cell Phone: _____
Has the patient ever had an eye exam? (circle) Yes No Date of Last Exam: _____/____/_____
Name of Previous Eye Doctor: _____ City: _____
Were glasses or contacts prescribed at this time? (circle) Yes No

GUARDIAN/ALTERNATIVE CONTACT INFORMATION

Name: _____ Relationship to Patient: _____
Cell Phone: _____

INSURANCE INFORMATION

Primary Member's Name: _____ Birth Date: ___/____/_____
Insurance Group and Number: _____ Social Security: ___-___-_____
Secondary Insurance Group and Number: _____
Primary Medical Doctor: _____ City: _____

MEDICAL HISTORY

Personal/Family History
Please indicate if the patient or any family members have a history of any of the following:

CONDITION	PATIENT	FAMILY	UNSURE	CONDITION	PATIENT	FAMILY	UNSURE
Blindness	☐	☐	☐	Arthritis	☐	☐	☐
Cataracts	☐	☐	☐	Cancer	☐	☐	☐
Glaucoma	☐	☐	☐	Diabetes	☐	☐	☐
Turned Eye	☐	☐	☐	Heart Disease	☐	☐	☐
Macular Degeneration	☐	☐	☐	High Blood Pressure	☐	☐	☐
Eye Injury	☐	☐	☐	Kidney Disease	☐	☐	☐
Eye Surgery	☐	☐	☐	Lupus	☐	☐	☐
Lazy Eye	☐	☐	☐	Thyroid Disease	☐	☐	☐

Other Health Conditions: _____
Allergic to medications? (circle) Yes No If yes, explain: _____
List any medications currently taking: _____
Ethnic Origin: ☐ Hispanic ☐ Caucasian ☐ African American ☐ Native American ☐ Asian ☐ Other

ANSWER IF UNDER 18:
Has the child been exposed to Tobacco products, Alcohol or Recreational drugs? (circle) Yes No
If yes, explain: _____
Was the child born premature? (circle) Yes No Has the child ever had a seizure? (circle) Yes No
Is the patient being treated for ADD/ADHD? (circle) Yes No If yes, medication? _____

ASSIGNMENT OF BENEFITS AUTHORIZATION

By signing below I understand that I am responsible for the balance on my account for any professional services rendered by Kid's Eye Site, regardless of my insurance status. I understand that it is my responsibility to pay any deductible amount, co-insurance or any remaining balance left unpaid by my insurance provider.

NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have had the opportunity to read Kid's Eye Site's Notice of Privacy Practices and Financial Policy.

Patient Name: _____

Signature: _____ Date: _____