Patient History Form for Children

Eyes of Chicago

Patient's Last Name	First Name	M.I.	☐ Male ☐ Female	Birth Date

Home Address	City	State	Zip

Best Phone Number	Email

Primary Member of Insurance Policy:	What is your Medical Insurance?
First & Last Name _____	Vision Insurance?
Date of Birth _____ Last 4 of SSN _____	

Were you referred to our office by anyone?_____ Is this your child's first eye exam? Yes No

If not, Date of last Vision Exam:_____ By Dr: _____

Primary Physician: _____ Date of last medical exam: _____ Age of Glasses _____

List Medications & Vitamins your child is taking: _____

Is your child allergic to any medications? No Yes, name:_____

Do his/her eyes feel dry, itchy, tear up often or appear red? No Yes, list:_____

Is your child struggling reading and/or with general school performance? No Yes, describe: _____

Do they complain of headaches/migraines, especially when reading? No Yes, describe: _____

Do you ever notice he/she squinting and/or holding objects very close? No Yes, describe: _____

Do your child's eyes ever drift or turn? No Yes, describe: _____

Check **Self and/or Relative** if any of these conditions apply to your child and/or relative:

	Self	Relative		Self	Relative	
Glaucoma	_____	_____	High Cholesterol	_____	_____	Other: _____
Cataracts	_____	_____	Macular Degeneration	_____	_____	
Diabetes	_____	_____	Retinal Disease	_____	_____	
Heart Disease	_____	_____	Thyroid Disease	_____	_____	
Hypertension	_____	_____	Retinal Detachment	_____	_____	

Release of Information

You may release any/and all information to the following members (Name/Relationships):

_____

Insurance Verification

You are **financially responsible** for all services, product charges, should your insurance consider any of these charge to be non-covered expenses. **Insurance** is not a guarantee of payment. Any and all refunds are processes at the end of each month.

Insurance coverage is the patient's responsibility. For any services other than routine eye coverage, we will bill your insurance company. If for any reason the claim is denied, you are responsible for payment in full.

Insurance must be presented at time of service. We will no longer be able to process any insurance and/or discounts at a later date.

_____
Initial

Notice of Privacy and Policy Practices

I acknowledge and have been made aware that Eyes of Chicago has a Notice of Privacy and Policy Practices handbook, a copy which has been offered for inspection if requested.

_____
Initial

Responsibility Statement/Acknowledgment of Privacy Practices

This form permits our office to computer generate, electronically file and/or personally file any and all claims pertaining to any visual insurance claim.

I, the patient, and/or responsible party, give permission to Eyes of Chicago, to release any information necessary to file for my insurance. I am fully aware that neither confidential information, nor any other information not routinely needed to filing my insurance will be release.

_____ _____

Date **Please Print Patient's Name**

_____

Signature of Patient/Guardian