SheridanEyeCare

Medical History—Student/Youth

Today's Date: _____/_____/_____

Patient's Last Name: _____ **First Name:** _____ **MI:** _____

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Phone: (H)_____ (W) _____ (Cell) _____ Birth Date: ____/____/____

E-mail: _____ Grade Level: _____

SSN: _____ - _____ - _____ Insurance: _____ Group and ID No.: _____

Responsible Party (Guarantor): Last Name: _____ **First Name:** _____ **MI:** ___

Guarantor's: Mailing Address: _____ City: _____ State: _____ ZIP: _____

Physical Address (If Different): _____ City: _____ State: _____ ZIP: _____

SSN: _____ - _____ - _____ Place of Employment: _____ Birth Date: ____/____/____

Phone: (H)_____ (W) _____

Allergy
Medication Allergies: _____ Environmental/Seasonal Allergies: _____

Please indicate if the patient has any of the following conditions:

Cardiovascular
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease

Constitutional/General
- ☐ Dizziness
- ☐ Recent Sickness (flu, cold)
- ☐ Cancer: please explain:

Cranial/Facial
- ☐ Hearing Loss
- ☐ Sinus Problems

Endocrine
- ☐ Diabetes If yes, for how many years? _____
- ☐ Thyroid Disease
- ☐ Kidney Disease

Gastrointestinal
- ☐ Acid Reflux
- ☐ Crohn's Disease
- ☐ Liver Disease

Immunologic:
- ☐ Herpes Simplex
- ☐ Herpes Zoster (Shingles)
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Frequent Cold Sores

Integumentary/Skin:
- ☐ Rosacea
- ☐ Skin Cancer

Neurologic
- ☐ Headache/Migraine
- ☐ Multiple Sclerosis

Psychiatric
- ☐ Depression
- ☐ Attention Deficit Disorder
- ☐ Dementia

Respiratory:
- ☐ Asthma
- ☐ COPD
- ☐ Bronchitis

Please see other side.

Please list other health conditions not mentioned above: _____

_____

Please list the patient's primary care doctor: _____

Height: _____ Weight: _____

Please list medications currently taken: _____

_____

_____

☐ I use cigarettes/tobacco regularly. ☐ I use alcohol regularly. ☐ I use other substances.

Family Medical History:

Please indicate if anyone in your family has: *Please indicate if on your maternal or paternal side.*

- ☐ Diabetes Relation: _____
- ☐ High Blood Pressure Relation: _____
- ☐ Heart Disease Relation: _____
- ☐ Cancer Relation: _____
- ☐ Other Relation: _____

Personal Eye History:

- ☐ I have had an eye operation. Which Eye? _____ Type: _____ Date: _____
- ☐ I have had an eye injury. Which Eye? _____ Type: _____ Date: _____
- ☐ I have other eye problems: _____

Family Eye History:

Please indicate if anyone in your family has: *Please indicate if on your maternal or paternal side.*

- ☐ Glaucoma Relation: _____
- ☐ Macular Degeneration Relation: _____

Please indicate if the patient has any of the following problems:

- ☐ Blur
- ☐ Double Vision
- ☐ Frequent squinting
- ☐ Falling behind in school
- ☐ Headaches
- ☐ Frequent eye rubbing
- ☐ Eye turn
- ☐ Tracking Problems
- ☐ Avoidance of reading
- ☐ Closing one eye when reading
- ☐ Holding reading material too close

Whom may we thank for referring you? _____

Please sign below, indicating that (1) you have had the opportunity to read our Notice of Privacy Practices, (2) authorizing the release of medical or other information necessary to process your insurance claim, and (3) authorizing insurance benefits to be paid directly to Sheridan Eyecare Center.

Promise to Pay: I understand that I am responsible for all services provided to me by Sheridan Eyecare and its staff. If I fail to pay for the services when they are rendered or if I fail to pay for services that are not paid by my insurance company, I will be responsible for all costs of collection, including but not limited to, interest at the rate of one and a half percent (1.5%) per month or eighteen percent (18 percent) per year, court costs and fees, attorney fees, and a collection fee of thirty five percent (35%) of the unpaid balance for collection.

_____

Signature