

Patient Health History

Patient Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Birth date: \_\_\_\_\_

Soc Sec#: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State \_\_\_\_\_ Zip: \_\_\_\_\_ Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary care physician: \_\_\_\_\_ Email \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Eye History

Do you currently wear glasses? Y N                      Have you worn contacts ? Y N

Do you want a new prescription for contacts? Y N

Do you have visual difficulty when reading with correction ? Y N

Do you have visual difficulty when driving with correction ? Y N

Are you currently using any prescription or non-prescription medication for your eyes? Y N

If Yes, Please list : \_\_\_\_\_

Have you ever had eye surgery? Y N

If yes, please describe: \_\_\_\_\_

Do currently have any of the following conditions?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Glaucoma               | <input type="checkbox"/> Halos             | <input type="checkbox"/> Macular degeneration       |
| <input type="checkbox"/> Cataracts              | <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Retinal tear or detachment |
| <input type="checkbox"/> Lazy eye/wandering eye | <input type="checkbox"/> Eye pain          | <input type="checkbox"/> Blurred Vision             |
| <input type="checkbox"/> Decreased vision       | <input type="checkbox"/> Double vision     | <input type="checkbox"/> Flashes of light           |
| <input type="checkbox"/> Floating dark spot     | <input type="checkbox"/> Redness           | <input type="checkbox"/> Burning                    |
| <input type="checkbox"/> Itching                | <input type="checkbox"/> Dryness           | <input type="checkbox"/> Sandy/gritty sensation     |
| <input type="checkbox"/> Foreign body sensation | <input type="checkbox"/> Discharge         | <input type="checkbox"/> Crusting on Eyelid         |
| <input type="checkbox"/> Drooping eyelid        | <input type="checkbox"/> Other _____       |   |

Are you currently being treated for any of the following?

High blood pressure    Diabetes    Heart Disease    Stroke    Arthritis    Pregnant

Please list any medications that you take,prescription or non-prescription:

\_\_\_\_\_

Please list any drug allergies: \_\_\_\_\_

Do you have other medical conditions that we should be aware of? \_\_\_\_\_

Use of Alcohol:  Never    Rarely    Moderate    Daily   How much? \_\_\_\_\_

Use of Tobacco:  Never    Previously, but not in the past \_\_\_\_\_years    Yes \_\_\_\_\_ packs/day

Family medical History

Does any one in your family have the following, if so which member

High blood pressure \_\_\_\_\_  Diabetes \_\_\_\_\_

Glaucoma \_\_\_\_\_  other eye disease \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my medical status

Signature of patient (or guardian, if minor) \_\_\_\_\_

Date \_\_\_\_\_

Primary Insurance

Patient Name: \_\_\_\_\_

Name of responsible Adult if other than Patient: \_\_\_\_\_

Date of birth of responsible party: \_\_\_\_\_

Name of health insurance \_\_\_\_\_

Name of vision insurance: \_\_\_\_\_

Insured ID# \_\_\_\_\_

**Secondary Insurance**

Name of responsible Adult if other than Patient: \_\_\_\_\_

Date of birth of responsible party: \_\_\_\_\_

Name of health insurance \_\_\_\_\_

Name of vision insurance: \_\_\_\_\_

Insured ID# \_\_\_\_\_

I certify that the above questions have been accurately answered. I understand that providing incorrect information may be dangerous to my health. I authorized the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services and/or materials. Any uncollected balance over 90 days will incur a 35% charge plus legal fees unless prior arrangements are made in writing.

If, for any reason, the insurance company or companies deny payment or allow less than the allowable charge, **I understand that I will be responsible for the full amount due. I also release Dr. Andrew S. Miller, O.D. Inc. from any liability regarding any insurance company's decision not to provide payment for specific services or materials. I understand that I am responsible for determining ahead of time whether or not I am eligible for vision care services.**

\_\_\_\_\_  
Signature (parent or guardian if under 18)

\_\_\_\_\_  
date

*Dr. Andrew S. Miller, O.D.  
4000 Virginia Beach Blvd  
Virginia Beach, VA 23452  
Phone 757-463-6769  
Fax 757-463-7270*

Many insurance companies require prior authorizations for any medical treatment. While you do not have to obtain an authorization for your routine eye exam, you do need to obtain one for visits for eye infections, injuries, and medical testing. By signing, you understand that it is your responsibility to obtain any prior authorization that may be needed. You also understand that if you are seen without obtaining prior authorization, you will be responsible for any claims that your insurance company denies.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
date

**Notice Of Privacy Practices Acknowledgment**  
***Dr. Andrew S. Miller***  
***4000 Virginia Beach Blvd***  
***Va. Beach, Va 23452***

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosure to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions

Patient Name: \_\_\_\_\_

Name of Responsible Party: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason:
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