

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 you 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 from 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 I have read understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information may be dangerous to my health. I authorized the Dr. 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 Dr. 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 an 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.**

I also understand that in compliance with federal regulations my records may only be kept for five years following the last encounter with the office

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 Privacy 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: _____

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:

PATIENT RECORD OF DISCLOSURES

I wish to be contacted in the following manner (check all that apply):

Home Telephone _____

- O.K. leave message with detailed information.
- Leave Message with call-back number only.

Work Telephone _____

- O.K. to leave message with detailed information.
- Leave Message with call-back number only.

Cell Phone: _____

- O.K. to leave message with detailed information.
- O.K. to text

Written Communication:

- O.K. to mail to my home address.
- O.K. to mail to my work/office address.
- O.K. to fax to this number _____

Patient Signature

date

Print Name

Birth date

Office use only

Date	Name and address or fax to whom disclosed to.	1	Reason for disclosure	By whom disclosed	2	3

1. Check this box if the disclosure is authorized
2. Type key: t = treatment records; P = payment information; o = Health care Operations
3. Enter how disclosure was made; f= fax; p = phone; e = email; M = Mail; O = other

optomap[®]

Retinal Exam

In our continued efforts to bring the most advanced technology available to our patients, Dr. Miller now offers the inclusion of the **optomap** Retinal Screening as an integral part of your eye exam. We recommend it for all patients once a year.

An **optomap** Retinal Screening provides:

- a scan to confirm a healthy eye or detect the presence of disease early
- an overview or map of the retina, giving your doctor a more detailed and wider view than can be achieved by the traditional "slit-lamp" exam
- the opportunity for you to view and discuss the **optomap** images of your eye with your doctor at the time of the exam
- a permanent record for your medical file, enabling your doctor to make important comparisons if potential problems show themselves at a future exam.

Our fee for the **optomap** Retinal Screening is \$39*.

_____ I have elected to have the **optomap** Retinal Screening today and understand that I will be
(initial here) charged a fee of \$39*.

_____ I would like the opportunity to talk with the doctor or technician about the **optomap** Retinal
(initial here) Screening.

Patient Signature _____ Date _____

*A **High Resolution** **optomap** Retinal Exam is recommended for any patient with a history of diabetes, glaucoma, hypertension, or any patient that has a screening and a problem presents. The High Resolution **optomap** Retinal Exam will be billed to your medical insurance along with any additional tests that may be required. **As a courtesy we will waive the fee for the screening and the patient will only be responsible for their standard specialist copay.** This copay **does not** include any copay for the annual routine vision exam.