Patient History Date_______________

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?

☐ Glaucoma ☐ Halos ☐ Macular degeneration
☐ Cataracts ☐ Light sensitivity ☐ Retinal tear or detachment
☐ Lazy eye/wandering eye ☐ Eye pain ☐ Blurred Vision
☐ Decreased vision ☐ Double vision ☐ Flashes of light
☐ Floating dark spot ☐ Redness ☐ Burning
☐ Itching ☐ Dryness ☐ Sandy/gritty sensation
☐ Foreign body sensation ☐ Discharge ☐ Crusting on Eyelid
☐ Drooping eyelid ☐ 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? ____________________________
Do you smoke? ☐ Yes ☐ No How much? ____pk For how long? _______
Does any one in your family have the following, if so which member
☐ High blood pressure ___________________________☐ Diabetes_______________________
☐ Glaucoma______________________________☐ other eye disease_______________________
Pharmacy Name and Address____
____

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 **Opto**map Retinal Screening as an integral part of you eye exam. We recommend it for all patients once a year.

An **Opto**map Retinal Screening provides:

- A scan to confirm a healthy eye or detect the presence of disease early.
- An overview of map of the retina, giving you 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 **Opto**map 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 **Opto**map Retinal Screening is $41.*

______ I have elected to have the **Opto**map Retinal Screening today and understand that I will be charged a fee of $41.00.

______ I would like the opportunity to talk with the doctor or technician about the **Opto**map Retinal Screening

Patient Signature:________________________________ Date:_____________

*A **High Resolution** **Opto**map 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.

Health Insurance

Patient Name: ____
Name of responsible Adult if other than Patient: ________________________________
Date of birth of responsible party:____
Insured ID# _______________________________

Secondary Health Insurance

Patient Name: ____
Name of responsible Adult if other than Patient: ________________________________
Date of birth of responsible party:____
Insured ID# _______________________________

Vision Insurance

Patient Name: ____
Name of responsible Adult if other than Patient: ________________________________
Date of birth of responsible party:____
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 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 form third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, and 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 disclosed 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.

Patients Name:____

Signature____

Date:____

PATIENT RECORD OF DISCLOSURES

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

Home Phone:

____ Ok to leave message with detailed information
____Leave message with call back number only

Work Phone

____ Ok to leave message with detailed information
____Leave message with call back number only

Cell Phone :

____ Ok to leave message with detailed information
____Leave message with call back number only
____ Ok to text

________________________________ __________________
Patient Signature Date

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

1 Check this box if disclosure is authorized 2 Type key: t= treatment;p=payment info.;o= healthcare operations
3 enter how disclosure was made. f=fax, p =phone;e=email,M=mail,O=other