Please take a few moments to fill out the following information. **Please be prepared to present your Insurance Card (s) and Drivers License or State ID with these forms along with a list of your Current Medications including eye drops, vitamins and supplements you may be taking.**

PLEASE PRINT

If you are new, how were you referred to our office ____________________

Patient Name ____
Last Name   First Name   Middle Initial

Parent/Guardian Name ______________________________________

Street Address ____

City ____________________ State ____________ Zip ____________

Home #(____) ____________ Work #(____) ____________ Cell #(____) ____________

Date of Birth ____/____/____ Current Age ____ Social Sec # ______-______-______

Sex M ☐ F ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐

Email address ____________________________________

Patient Employer ____________________________ Phone ____________

Occupation ____________________________________

Medical Insurance Information

Subscribers Name ____________________________ Date of Birth ____/____/____

Vision Insurance Information

Subscribers Name ____________________________ Date of Birth ____/____/____

Family Physician ____________________________ Phone ____________

Other Physician (s) you would like a letter sent to. Please include phone number (s).

____

Emergency Contact ____________________________ Phone ____________

Relationship ____________________________________

____

Patient / Parent or Guardian Signature **Date**

MEDICAL HISTORY QUESTIONNAIRE

Name: ______________________________ **Date of Birth:** ____/____/______

Referring Doctor: ______________________ **Primary Care Physician:** ______________________

Pharmacy Name and Location (street & city): ______________________

Date of last eye exam ______________ **Name of Doctor / Facility** ______________________

Do you wear glasses? ☐ Yes ☐ No Do you wear contacts? ☐ Yes ☐ No Type/Brand ______________

Ocular History: (Please mark all that apply) ☐ No history of eye problems

☐ Amblyopia (Lazy Eye)
☐ Iritis/Uveitis
☐ Cataracts
☐ Corneal Disorder
☐ Diabetic Retinopathy
☐ Astigmatism
☐ Glaucoma
☐ Hyperopia (Farsighted)
☐ Floaters
☐ Dry Eye Syndrome
☐ Myopia (Nearsighted)
☐ Retinal Detachment
☐ Eyelid Disorders
☐ Macular Degeneration

Other ______________________

Past Ocular Surgeries: (Please mark all that apply) ☐ No prior ocular surgery

R - L
☐ ☐ Blepharoplasty (Lid Surgery)
☐ ☐ Cataract Surgery
☐ ☐ Corneal Transplant

R - L
☐ ☐ Glaucoma Surgery / Laser
☐ ☐ Laser Retinal Surgery
☐ ☐ LASIK

R - L
☐ ☐ Strabismus (eye muscle surgery)
☐ ☐ Vitrectomy
☐ ☐ YAG Laser Capsulotomy

Other ______________________

Other Medical History: ☐ No history of illnesses Are you Pregnant? ☐ Yes ☐ No

☐ Anemia
☐ Arthritis
☐ Arrhythmia
☐ Asthma
☐ Cancer (specify below)
☐ Congestive Heart Failure
☐ COPD
☐ Diabetes (circle: Type 1 or Type 2)
☐ Fibromyalgia
☐ Headache
☐ Hearing Loss
☐ Heart Attack
☐ Hepatitis
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV/AIDS
☐ Kidney Disease
☐ Liver Disease
☐ Lupus
☐ Migraine
☐ Multiple Sclerosis
☐ Polymyalgia Rheumatica
☐ Psychiatric Disorder
☐ Rheumatoid Arthritis
☐ Stroke
☐ Thyroid Disease

Other ______________________

Previous General Surgeries/Procedures: (Please list type and year)

______________ ______________ ______________

______________ ______________ ______________

Allergies:	**Reaction**	**Severity**
______________	______________	mild / moderate / severe
______________	______________	mild / moderate / severe
______________	______________	mild / moderate / severe

Family History: (Please indicate relationship) ☐ No history of illnesses ☐ History unknown

☐ Blindness
☐ Cancer
☐ Cataracts
☐ Diabetes
☐ Glaucoma
☐ Heart Disease
☐ High Blood Pressure
☐ Lazy Eye
☐ Macular Degeneration
☐ Retinal Disease
☐ Stroke
☐ Other ______________

Social History: (Please mark all that apply)

Smoking: ☐ current every day smoker ☐ current some day smoker ☐ former smoker ☐ never smoked

Alcohol Use: ☐ No ☐ Yes If yes, how much and how often? ______________

Drug Use: ☐ No ☐ Yes If yes, which and how long? ______________

Patient/Parent or Guardian Signature ______________________ Date ______________

Medication Sheet

Name:______________________________ Date: __________

Did you get a flu shot: Y N

Current Eye Medications: (Please list)

□ None

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

All Other Medications: (Please list and include any aspirin or vitamins)
□ None

Medication name	Dose	Directions	Reason for taking	Prescriber name

Patient/Parent or Guardian Signature ______________________________

Date ______________

IMPORTANT INFORMATION ABOUT OUR INSURANCE POLICIES

Every day new insurance companies are forming, and present companies are changing. Consequently, it is impossible for us to know exactly what your insurance company will cover. Please check with your own insurance carrier, so you will be aware of your coverage and eligibility regarding: **OFFICE VISITS, TEST, SURGERY, ROUTINE EYE EXAM, GLASSES, CONTACTS, ETC.** It is to your benefit to be well informed to prevent having to pay for a service that may have been covered if you had a referral or prior authorization.

It is our policy to make a copy of your Insurance Cards (Medical and Vision). Please be prepared to present these to the receptionist.

- *I understand if I do not carry medical or vision insurance for the exam performed, I will be asked to pay at the time of service.*
- *I understand that Millman-Derr Center for Eye Care and/or M.D. Optical collects for all co-pays, deductibles and any charges not covered by my insurance.*
- *I understand that I am responsible for my bill for charges not covered by my insurance.*
- *I authorize release of information to all my insurance companies.*
- *I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.*
- *I authorize direct payment to my doctor.*
- *I permit a copy of this authorization to be used in place of the original.*
- *If I have managed care insurance (HMO), I am responsible for obtaining a referral from my Primary Care Physician prior to my appointment. I understand that my appointment will be canceled/rescheduled if I do not have a referral when I arrive for my appointment.*
- *I understand that if I am seen for a Routine Vision Exam, medical testing might be necessary and ordered by the doctor. Medical testing is generally not covered by vision insurance companies. Millman-Derr Center for Eye Care and /or M.D. Optical will bill my medical carrier for these test as necessary. Eye Refraction is not covered by Medicare.*
- *I authorize the release of medical records to any physicians I may be referred to.*
- *By signing this, I am aware that Millman-Derr Center for Eye Care has a Notice of Privacy in place and I may review a copy of it in the office or ask for a copy to be given to me for my records.*

Please sign below that you have read and understand the above:

____

Patient/Parent of Guardian Signature Date

____

Patient Printed Name Date

RELEASE OF MEDICAL INFORMATION

May we give your test results and any medical information to a family member if you are not available?

YES _____ NO_____

If Yes, please list their name below:

____

____

May we leave test results on your voice mail? YES_____ NO_____

Millman-Derr Center for Eye Care, P.C.

MD Optical LTD

______________________________ ______________________

Patient Signature Date

Revised FEB 2019