MILLMAN-DERR CENTER FOR EYE CARE

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

PLEASE PRINT

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: _____ SSN#: _____

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

Email Address: _____

Patient Employer: _____

Occupation: _____

Patient Primary Care Physician: _____

Phone #: _____ Fax #: _____

Other Physician(s) you would like a letter sent to. Please include Phone and Fax #
_____

Emergency Contact: _____ Phone #: _____

Relationship _____

_____
Patient/Parent or Guardian Signature Date

MILLMAN-DERR CENTER FOR EYE CARE

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 MD 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 a 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 cancelled/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, medial 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 MD Optical will bill my medical carrier for these test as necessary. <u>Eye Refraction is not covered by Medicare</u>.*
- *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

MILLMAN-DERR CENTER FOR EYE CARE

NAME:				DATE:	
DOB:				GENDER:	
PRIMARY CARE PHYSICIAN :					
ADDRESS :					
PHONE:					
DO YOU WEAR ANY OF THE FOLLOWING: (PLEASE CIRCLE)					
GLASSES		CONTACT LENSES		GLASSES AND CONTACT LENSES	NONE
PLEASE CIRCLE ANY EYE CONDITIONS YOU HAVE PRESENTLY OR HAVE HAD IN THE PAST:					
DRY EYES		MACULAR DEGENERATION		GLAUCOMA	CATARACTS
RETINAL DETACHMENT (PLEASE SPECIFY):		KERATOCONUS		OTHERS (PLEASE SPECIFY):	
COMMENTS:					
PLEASE CIRCLE ANY EYE CONDITIONS A FAMILY MEMBER OR BLOOD RELATIVE HAVE					
PRESENTLY OR HAVE HAD IN THE PAST:					
DRY EYES		MACULAR DEGENERATION		GLAUCOMA	
RETINAL DETACHMENT		KERATOCONUS		OTHERS (PLEASE SPECIFY):	
COMMENTS:					
PLEASE CIRCLE ANY MEDICAL CONDITIONS YOU HAVE PRESENTLY OR HAVE HAD IN THE PAST:					
HIGH BLOOD PRESSURE			HEART PROBLEM	ARTHRITIS	LUNG PROBLEMS
STROKE		THYROID PROBLEMS		DIABETES	HEP C
ULCERS		CANCER		OTHERS (PLEASE SPECIFY):	
CHOLESTEROL					
PLEASE CIRCLE ANY MEDICAL CONDITIONS A FAMILY MEMBER OR BLOOD RELATIVE HAVE					
PRESENTLY OR HAVE HAD IN THE PAST:					
HIGH BLOOD PRESSURE			HEART PROBLEM	ARTHRITIS	LUNG PROBLEMS
STROKE		THYROID PROBLEMS		DIABETES	
ULCERS		CANCER		OTHERS (PLEASE SPECIFY):	
CHOLESTEROL					

MILLMAN-DERR CENTER FOR EYE CARE

HAVE YOU HAD A FLU VACCINATION?							
NO	YES						
HAVE YOU HAD A COVID VACCINATION?							
NO	YES						
PHARMACY NAME:							
ADDRESS:							
PHONE/FAX:							
PLEASE LIST ALL MEDICATIONS THAT YOU TAKE:							
EYE DROPS:							
PRESCRIPTION MEDICATIONS:							
VITAMINS OR SUPPLEMENTS:							
SMOKING STATUS: PLEASE CIRCLE THE STATEMENT THAT APPLIES:							
NEVER		FORMER SMOKER		CURRENT SMOKER			
DO YOU DRINK ALCOHOL:							
NO	YES (***PLEASE SPECIFY):***						
HAVE YOU HAD ANY EYE SURGERIES? (IF YES, PLEASE SPECIFY)							
NO	YES:						
HAVE YOU HAD ANY GENERAL SURGERIES? (IF YES PLEASE SPECIFY)							
NO	YES:						
DO YOU HAVE ANY MEDICATION ALLERGIES:							
ARE YOU PREGNANT OR NURSING?	***NO***	***YES***					

MILLMAN-DERR CENTER FOR EYE CARE

HIPPA/ 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

MD SurgiCenter

_____ _____

Patient Signature Date

Revised FEB 2019