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

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_____

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**

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. <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

PATIENT HISTORY (Please Print)

NAME :	DATE :
DOB :	GENDER :
PRIMARY CARE PHYSICIAN NAME:	
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	Keratoconus	Others *(please specify below)*

Comments:

Please circle any eye conditions a family member or blood relative have presently or have had in the past: (please specify relationship)

Dry Eyes	Macular Degeneration	Glaucoma	Cataracts	Retinal Detachment	Keratoconus	Others *(please specify below)*

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
LDL	Ulcers	Cancer	Others *(please specify)*:			

Please circle any medical conditions a family member or blood relative have presently or have had in the past: ***(please specify relationship)***

High Blood Pressure	Heart Problem	Arthritis	Lung Problems	Stroke	Thyroid Problems	Diabetes
LDL	Ulcers	Cancer	Others *(please specify)*:			

Have you had a FLU vaccination?

___ No ___ Yes

PHARMACY NAME :

ADDRESS :

PHONE / FAX :

Please list all MEDICATIONS that you take :

Eye Drops :

General Medications :

Smoking status: please select the statement that applies :

___ Never smoked ___ Former smoker ___ Current smoker

Do you drink alcohol?

___ No ___ Yes, please specify how much:

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 ALLERGIES? ***(If yes, please specify)***

___ No ___ Yes

Are you PREGNANT or NURSING?

___ No ___ Yes

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