Norman & Miller Eyecare *Registration & Health History*

Date: _____
Name: _____ Date of birth:_____ SSN: _____
Address _____ City: _____ State: ____ Zip:_____
Cell Phone: _____ Email:_____
Occupation:_____ Employer:_____

IF USING INSURANCE TO PAY FOR ANY PART OF TODAY'S VISIT PLEASE SPECIFY BELOW

Vision/Medical Insurance: _____ Supplement: _____

*Who is your primary care physician?*_____
*What is your reason for today's visit?*_____
Are you interested in new glasses today? Yes / No
Are you interested in contacts today? Yes / No *Are you currently a contact lens wearer? Yes / No*
Are you interested in sunglasses today? Yes / No ***Previous Eye Doctor:*** _____
Any hobbies or tasks you perform that you would like a different pair of glasses for? Yes / No
If yes above, please describe: _____
Have you ever had an eye injury or surgery? Yes / No
If yes above, please describe: _____
Do you currently take any ***eye*** *medications? Yes / No*
*If yes above, please describe:*_____

Dilation

Dilation of the pupils allows the doctor to obtain a more thorough view of the retina. Our doctors like to do this on every diabetic or if they feel the need to have a better look of the back of the eye. The doctor would place a couple of drops in each eye that would increase your pupil size. The most common side effects include light sensitivity, decreased near vision and glare. It will take anywhere from 15-30 minutes for your pupils to dilate and the side effects will last anywhere from 2-4 hours. Any retinal problems that are not found should you choose **not** to be dilated, will **not** be the doctor's responsibility. The doctor will be happy to discuss dilation with you during your exam.

I understand the importance of dilation and _____ I DO want my eyes dilated if necessary
_____ I DO NOT want my eyes dilated

Authorization and Release

I authorize all doctors at Norman & Miller Eyeare to release any information including the diagnosis and the records of any treatment rendered to me or my child during the period of such eye care to third party payers, health practitioners, and/or employers until requested in writing. I assign all insurance benefits, if any, to Norman & Miller Eyecare for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that the exam and materials **must** be paid for in full a the time of service. There is a 90-day reutrn policy on contacts. After 90 days we can not take boxes of contacts back. We accept cash, check, and all major credit cards. An overdraft fee of $25.00 will be assessed for all returned checks. Patient(s) shall still be responsible for any attorney fees, collection agency fees, cost of collection, court costs and any other expenses or fees. Contact lenses examinations may be subject to a contact lens fitting fee or a refitting fee with one free follow-up appointment. All other contact lens checks or follow-up appointments may include additional fees. I understand every pair of eyewear purchased from Norman & Miller Eyecare is custom made to my needs and cannot be returned. In the event of a refund, I understand I may be charged a restocking fee of 20%. I understand if I choose a less expensive frame or lens option, fees may be retained by Norman & Miller Eyecare. I have read the contents of this page and understand by signing my name, I agree to all of the terms and conditions. I have read the Norman & Miller Eyecare HIPAA Notice of Privacy Policy either on the website or in the office.

To comply with the new HIPAA Federal Privacy Regulations, we must receive your written approval to discuss your information with anyone (including family). By authorizing this, we will be able to , without requiring your presence, discuss your case, answer questions, and leave detailed messages and contact in case of an emergency, the person listed to the right.

Name: _____
Relationship: _____
DOB: _____
Phone: _____

Signature: _____ TURN THIS PAGE OVER ---------->

Personal Medical History:

Please check ALL conditions for which you are being treated, or take medications for.

Constitutional:
___ *Developmental Disabilities*
___ *Cancer*
___ *Fatigue Syndrome*
___***None***

Neuro:
___ *Multiple Sclerosis*
___ *Epilepsy*
___ *Cerebral Palsy*
___ *Tumor*
___ *Stroke/CVA*
___ *Migraine*
___ *Autism*
___***None***

GI:
___ *Crohn's*
___ *Colitis*
___ *Ulcer*
___ *Acid Reflex*
___ *Celiac Disease*
___***None***

Hem/Lymph:
___ *Anemia*
___ *Large-Volume Blood Loss*
___ *High Cholesterol*
___***None***

ENT:
___ *Hearing Loss*
___ *Sinusitis*
___ *Dry Mouth*
___ *Laryngitis*
___***None***

Endo:
___ *Type 2 Diabetes*
___ *Type 1 Diabetes*
___ *Thyroid Dysfunction*
___ *Hormonal Dysfunction*
___***None***

Cardiovascular:
___ *High Blood Pressure*
___ *Congestive Heart Failure*
___ *Heart Disease*
___ *Vascular Disease*
___ *Stroke/CVA*
___***None***

Integ:
___ *Eczema*
___ *Rosacea*
___ *Psoriasis*
___ *Herpes Simplex/Cold Sores*
___ *Herpes Zoster/Shingles*
___***None***

Psych:
___ *Depression*
___ *Attention Deficit*
___ *Anxiety Disorder*
___ *Bipolar Disorder* ___***None***

Respiratory:
___ *Cigarette Smoker*
___ *Asthma*
___ *Bronchitis*
___ *Emphysema*
___ *COPD*
___ *Sleep Apnea* ___***None***

Musc/Skel:
___ *Osteoarthritis*
___ *Arthritis*
___ *Fibromyalgia*
___ *Muscular Dystrophy*
___ *Ankylosing Spondylitis*
___ *Osteoporosis*
___ *Gout* ___***None***

Allergy/Imm:
___ *Environmental Allergies*
___ *Rheumatoid Arthritis*
___ *Lupus*
___ *Sjogren's Syndrome*
___***None***

GU:
___ *Kidney Disease* ___ *Prostate Disease/Cancer* ___ *STD-Herpetic/Chlamydia*
___ *Benign Prostate Hypertrophy* ___ *Herpes* ___ *Chlamydia* ___ *HIV/AIDS*
___ *Tuberculosis* ___ *Hepatitis* ___ *Pregnant* ___ ***None***

Have you ever been diagnosed with:
___ *Cataracts*
___ *Glaucoma*
___ *Retinal Detachment*
___ *Lazy Eye/Amblyopia*
___ *Macular Degeneration*
___ *Dry Eyes*
___ *Strabismns/Eye Turn*
___ *Retinal Hole*
___ *Blindness*
___ *Other*_____
___***None***

Please Initial Below

Family Health History: Use indicators below

M = Mother F = Father S = Sister B = Brother

___ *Cancer*
___ *High Blood Pressure*
___ *Type 1 Diabetes*
___ *Type 2 Diabetes*
___ *Thyroid Hyper*
___ *Thyroid Hypo*
___ *Cataracts*
___ *Glaucoma*
___ *Macular Degeneration*
___***None***

Please list all medications you are taking:
Include all vitamins and supplements
Note: We will copy your list of medications for you

_____
_____
_____

Please list all medications you are ALLERGIC to:

_____