DR. MILLER WELCOMES YOU TO OUR OFFICE!

Thank you for choosing our practice for your eye care needs. So that we may better care for you, please fill out the following information. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help! All responses will be kept in strictest confidence.

Patient's Name: _____ Date: _____
FIRST MI LAST

PATIENT'S SSN: _____ ☐ Male ☐ Female Birthdate: _______________ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

E-Mail Address: _____ Home Phone: _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widow\Widower

Patient's Employer or School: _____ Occupation or Grade: _____

Business Address: _____Work Phone: _____

Person To Contact In Case Of Emergency: _____ Phone # : _____

Whom May We Thank For Referring You To Us? _____

RESPONSIBLE PARTY

Name Of Person Responsible For This Account: _____

Relationship To Patient: _____ SSN: _____ Phone # : _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone # : _____

VISION INSURANCE INFORMATION \ PAYMENT AGREEMENT

Name Of Insured: _____ Relationship To Patient: _____

Birthdate: _______________ Insured's Social Security Number: _____

Name Of Employer: _____ Work Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

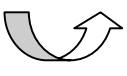
Insurance Company: _____ Group #: _____

Insurance Co. Address: _____City: _____ State: _____Zip: _____

I hereby authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and\or health practitioners. I authorize the use of this signature on all insurance submissions. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.
Our office honors Cash, Check, Discover, Visa, and Mastercard as payment. Professional fees are payable at the time of service. If eyewear or contact lenses are to be ordered, a minimum of 50% deposit is required and the balance is due upon delivery. A "prompt pay courtesy" is not available to those patients who have an insurance with which this office participates.

I have read and agree to all the provisions of the office financial policy.

Signature of patient (or parent if minor): _____ Date: _____



MEDICAL HISTORY FORM

Patient Name: _____ **Today's Date:** _______________

The information in this confidential personal history form is critical to the evaluation of your visual system.

Family Physician's Name: _____ **Date of last visit:** _______________

Reason for today's visit: _____

Are you interested in purchasing new glasses today? Yes . . . .No

Are you interested in contact lenses? Yes . . . No

Please list any visually demanding hobbies _____

Review of Systems: Please indicate any PERSONAL history below: (Circle No Or Yes)

☐ Constitutional Systems

Good general health lately . . .	No	Yes
Fatigue Syndrome.	No	Yes
Developmental disability	No	Yes
Cancer	No	Yes

☐ Ears/Nose/Mouth/Throat

Sinusitis	No	Yes
Hearing loss	No	Yes
Laryngitis	No	Yes
Dry throat or mouth	No	Yes

☐ Neurological

Multiple Sclerosis	No	Yes
Epilepsy	No	Yes
Cerebal Palsy	No	Yes
Tumor	No	Yes
Stroke/CVA	No	Yes
Migraine	No	Yes

☐ Psychiatric

Depression.	No	Yes
Bipolar disorder	No	Yes
Anxiety	No	Yes
Attention deficit (ADD)	No	Yes

☐ Cardiovacular

Congestive Heart Failure	No	Yes
Vascular disease	No	Yes
Heart Disease	No	Yes
Stroke/CVA	No	Yes
Hypertention/Blood pressure. . .	No	Yes

☐ Respiratory

Chronic obstruction (COPD) . . .	No	Yes
Emphysema	No	Yes
Sleep Apnea	No	Yes
Asthma	No	Yes
Bronchitis	No	Yes
Cigarette smoker	No	Yes

☐ Gastrointestinal

Acid Reflux	No	Yes
Ciliac Disease	No	Yes
Ulcers	No	Yes
Colitis	No	Yes
Crohn's	No	Yes

☐ Genitourinary

Kidney disease	No	Yes
Currently pregnant/nursing	No	Yes
BPH (prostate).	No	Yes
Prostate cancer	No	Yes
Chlamydia	No	Yes
Herpes	No	Yes

☐ Musculoskeletal

Fibromyalgia	No	Yes
Muscular dystrophy. . . .	No	Yes
Arthritis	No	Yes
Osteoarthritis	No	Yes
Gout	No	Yes
Ankylosing spondylitis ..	No	Yes
Osteoporosis	No	Yes

☐ Integumentary

Herpes simplex/cold sores	No	Yes
Psoriasis	No	Yes
Rosacea	No	Yes
Eczema	No	Yes
Herpes Zoster/Shingles . .	No	Yes

☐ Endocrine

Type 2 Diabetes	No	Yes
Type 1 Diabetes	No	Yes
Thyroid dysfunction	No	Yes
Hormonal dysfunction . . .	No	Yes

☐ Hematologic/Lymphatic

High cholesterol	No	Yes
Ulcers	No	Yes
Anemia	No	Yes

☐Allergy/Immune

Rheumatoid arthritis	No	Yes
Environmental allergies.	No	Yes
Sjogrens syndrome..	No	Yes
Lupus	No	Yes

☐ Past Ocular history

Retinal hole	No	Yes
Cataract	No	Yes
Macular degeneration . .	No	Yes
Surgery	No	Yes
Patching	No	Yes
Inflammatory disorder . .	No	Yes
Strabismus (turned eye) .	No	Yes
Amblyopia (lazy eye) . . .	No	Yes
Dry eye	No	Yes
Nystagmus	No	Yes
Keratoconus	No	Yes
Injury	No	Yes
Glaucoma suspect	No	Yes
Glaucoma	No	Yes

☐ Social History

Smoking status: Please circle:

Never smoker
Previous smoker
Current smoker occasional
Current smoker every day

List drug or environmental allergies:

_____

_____

_____

List Medications You Are Taking (Include Non-Prescription) _____

_____

_____

Please indicate any FAMILY history below: (Circle No Or Yes)

☐ Medical

Cancer	No	Yes
Diabetes	No	Yes
Thyroid disease	No	Yes
High blood pressure.	No	Yes

☐ Ocular

Nystagmus	No	Yes
Retinal detachment	No	Yes
Dry Eye Syndrome	No	Yes
Glaucoma Suspect	No	Yes
Macular degeneration . .	No	Yes
Cataract	No	Yes
Glaucoma	No	Yes
Strabismus (turned eye).	No	Yes
Amblyopia (lazy eye) . .	No	Yes