Welcome to Miller Vision Specialties

Name: ____ **Date:** ____________________

Address: ____ **Phone:** ____________________

____ **Cell:** ____________________

Parent/Guardian ____________________________ **Email:** ____

Insurance Information

Miller Vision Specialties participates with the following insurance carriers: Please Circle

Blue Cross Blue Shield	**Medicare**	**Blue-Med**	**Aetna**	**Eyemed**
United Health Care	**Medicare Complete**	**Medcost**	**UMR**	**VSP**

Bill Payer (Subscriber) ____________________________ Birth date (Subscriber ______________________________

Social Security ______________________________

Payment is expected at time of service for fees not allowable by your insurance carrier.

Insurance companies do not guarantee payment. Any additional balance will be billed to your account.

Note: We do not file secondary insurance

I hereby assign all medical and/or vision benefits, to which I am entitled, from my insurance plans, to: Miller Vision Specialties

Authorization to Release Information: I authorize the undersigned hereby said provider to release all information pertaining to patient treatment to his/his insurance companies and to any other physician or health care provider to whom the undersigned may be referred.

Consent to Treat: I hereby authorize medical treatment of myself/minor by the doctors of Miller Vision Specialties. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made concerning my care.

Advance Beneficiary Notice (ABN)

Insurance companies may not pay for certain tests and materials. If my insurance company denies payment, I agree to be personally and fully responsible for payment. An ABN form has been made available to me.

Notice of Privacy Practices

I understand that, under the Health Insurance Portability and Accountability Act of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

*Obtain payment from third-party payers

*Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that a copy of the Notice of Privacy Practices has been made available to me containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the Notice of Privacy Practices form time to time and that I my contact this organization at any time to obtain a current copy. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Additional Authorized Names: ____

Signature: ____

Name you wish to be called:______________________ **Age:**________ **Birthdate:**______________

Date of Last Eye Exam: ______________ **Medical Doctor:** ___________ **Occupation:** ____________

Do you wear contacts? Yes No
What solution do you use? ____________________
Do you sleep in your contacts? Yes No
If no, would you like to try contacts? Yes No

Do you wear glasses? Yes No
How old are your glasses? ______________
Smoking Yes No
Alcohol Yes No
Pregnant Yes No

Eye Health

Blurry vision	Crossed eyes	Drooping eyelids	Glaucoma	Retinal detachment
Dry eye	Eye injury	Watery eye	Red eye	Macular degeneration
Eye surgery	Lasik	Floaters	Flashes	Light Sensitive
Sties/Chalazion	Eye Pain	Soreness of eye	Burning	Foreign body sensation
Mucus discharge	Sandy/gritty	Itching	Double Vision	

Medical Systems

Do you have any problems with the following systems? Please check

Ear/Nose/Throat			**Musculoskeletal**			**Genitourinary**		
Allergies	Yes	No	Arthritis	Yes	No	Kidney	Yes	No
Sinus	Yes	No	MS	Yes	No	Bladder	Yes	No
Neurological			**Endocrine**			Genitals	Yes	No
Headaches	Yes	No	Thyroid	Yes	No	**Lymph/Hematologic**		
Migraines	Yes	No	Diabetes	Yes	No	Anemia	Yes	No
Respiratory			Lupus	Yes	No	Bleeding	Yes	No
Asthma	Yes	No	**Vascular/Cardio**			**Constitutional**		
Emphysema	Yes	No	Heart	Yes	No	Weight loss	Yes	No
Integumentary/Skin	Yes	No	Stroke	Yes	No	Weight gain	Yes	No
Allergic/Immunologic	Yes	No	Blood Pressure	Yes	No	Cancer	Yes	No
Gastrointestinal	Yes	No	Psychiatric	Yes	No			

If you answered yes to any of the above or have any other condition please explain____

Medications

List all medications you take (including vitamins, oral contraceptives and over the counter)_________________

____

____Do you use other substances? List_______________

Are you allergic to any medications? Yes No
Please list____

Family History

Does anyone in your family have any of the following conditions? Please check.

Glaucoma	**Retinal Problems**	**Crossed Eyes**	**Macular Degeneration**	**Eye Disease**
Arthritis	**Diabetes**	**Heart Disease**	**High Blood Pressure**	**Thyroid**
Cancer	**Kidney**	**Lupus**		

Official Use: **Doctor Signature**______________________________ **Date**___________________