Milam's
COMMUNITY EYE CARE
770 483-4831

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to help you.

PATIENT INFORMATION

Name: _____ Sex: _____ Age: _____

Address: _____ Birthdate: _____

City, State, Zip: _____ SSN: _____

Home Phone: _____ Work Phone: _____ ext. _____ *Cell Phone: _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Spouses Name: _____

Email: _____

Occupation: _____ Employer: _____

Work Address: _____ City, ST: _____ Zip: _____

OPTIONAL

Do you wear glasses? ☐ Yes ☐ No How often _____

Do you wear contacts? ☐ Yes ☐ No How often _____ What brand? _____

Reason for visit today?: _____

MEDICAL & INSURANCE INFORMATION

Medical Insurance: _____ Vision Insurance: _____

Please list primary on insurance (if other than you) _____ DOB _____ Last 4 of SSN: _____

ACCOUNT RESPONSIBLE

Name: _____ Address: _____

City, State, Zip: _____

Work: _____ ext _____ Cell Phone: _____

EMERGENCY INFORMATION

Friend or Relative Not Living at Home:

_____

Daytime Phone Number:

_____

Other Emergency Phone Number:

_____

REFERRED BY

☐ Employer ☐ Friend ☐ Doctor

☐ Insurance ☐ Family Member

☐ Yellow Pages ☐ Location

☐ Other (please specify on line below)

_____

☐ Check this box if this individual is a Milam's patient

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NAME: _____

DATE OF BIRTH: _____

DATE: _____

PERSONAL MEDICATION LIST

Prescription Medications	Purpose or Reason Taken	Dose	Time(s) of Day	Form (Liquid, capsule, tablet)	Special Instructions

Over-the-Counter Medications	Purpose or Reason Taken	Dose	Time(s) of Day	Form (Liquid, capsule, tablet)	Special Instructions

Do you have any drug allergies? ☐ YES ☐ NO

If Yes please list: _____

_____

_____

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NAME: _____

Date of Birth: _____

Todays Date: _____

EYE HEALTH HISTORY

Date of last eye exam _____

Name of last eye doctor _____

Do you wear glasses? ☐ Yes ☐ No

Do you wear contacts? ☐ Yes ☐ No

Type _____ Brand _____

Hours/Day _____

Describe any problems you have with your contacts: _____

_____

_____

_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Glaucoma *(If yes, please list drops used in medication section of Exam form)*	☐ Yes ☐ No	Dry Eyes	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Temporary Loss of Vision	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No	Eye Pain or Soreness	☐ Yes ☐ No
Eye Surgery	☐ Yes ☐ No	Double Vision	☐ Yes ☐ No
Eye Injuries	☐ Yes ☐ No	Excessive Tearing	☐ Yes ☐ No
Retinal Disease	☐ Yes ☐ No	Itchy Eyes	☐ Yes ☐ No
Retinal Detachment	☐ Yes ☐ No	Burning or Red Eyes	☐ Yes ☐ No
Color Blindness	☐ Yes ☐ No	Flashes	☐ Yes ☐ No
Blindness (Complete Vision Loss)	☐ Yes ☐ No	Floaters	☐ Yes ☐ No
Strabismus (Lazy Eye / Crossed Eyes)	☐ Yes ☐ No	Glare Problems	☐ Yes ☐ No
Amblyopia (Uncorrectable Blurry Vision)	☐ Yes ☐ No	Light Sensitivity	☐ Yes ☐ No
Refractive (Correctable Blurry Vision)	☐ Yes ☐ No		
If yes, blurry distance or near vision or both _____			

Other eye problems (please list): _____

_____

HEALTH HISTORY

Primary Care Physician's Name _____

Specialty Physician's Name(s) _____

Last medical exam _____ with Dr. _____

(PH) Have you ever had any surgery, major injuries and/or been hospitalized? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any Drug Allergies? ☐ Yes ☐ No

If yes, please list: _____

REVIEW OF SYSTEMS

Please "X" the appropriate column and Circle conditions that apply.

☐ Yes ☐ No CONSTITUTIONAL, developmental disability, cancer, fever/chills, recent weight loss or gain, fatigue

☐ Yes ☐ No CARDIOVASCULAR HEART, high blood pressure, heart disease, vascular disease, stroke, irregular heartbeat

☐ Yes ☐ No ENDOCRINE, Insulin dependent diabetes, non insulin dependent diabetes, thyroid problems, hormonal problems

☐ Yes ☐ No NEUROLOGICAL, headaches, multiple sclerosis, cerebral palsy, tumor, seizures, numbness or tingling in extremities

☐ Yes ☐ No PSYCHIATRIC, dementia, anxiety, memory loss, difficulty concentrating, insomnia

☐ Yes ☐ No EARS/NOSE/MOUTH/THROAT, hearing loss, sinus problems, dry mouth, mouth sores

☐ Yes ☐ No ALLERGIC/IMMUNOLOGIC, environmental allergies, rheumatoid arthritis, lupus, HIV/AIDS

☐ Yes ☐ No RESPIRATORY, Asthma, bronchitis, emphysema, COPD, cough

☐ Yes ☐ No MUSCULOSKELETAL, Arthritis, Fibromyalgia, muscular dystrophy, ankylosing spondylitis, back or neck pain

☐ Yes ☐ No GASTROINTESTINAL, heartburn, crohn's disease, ulcer, colitis

☐ Yes ☐ No GENITOURINARY, kidney problems, prostate problems, frequent urination, sexually transmitted disease

☐ Yes ☐ No HEMATOLOGIC/LYMPHATIC, high cholesterol, anemia, blood loss, sickle cell, leukemia

☐ Yes ☐ No INTEGUMENTARY/SKIN, rosacea, psoriasis, skin cancer, rash

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NAME: _____

Date of Birth: _____

Todays Date: _____

SOCIAL HISTORY

Are you pregnant or nursing? ☐ Yes ☐ No ☐ N/A

Do you use tobacco products? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Occupation_____

Do you use a computer at work? ☐ Yes ☐ No

if yes, how many hours daily? _____

Please list Sports / Hobbies that you participate in regularly:

_____

_____

_____

FAMILY HISTORY

Please Identify if any blood relatives has had any of the following problems:
(If yes, please explain relationship to you)

	YES	NO	RELATIONSHIP
Glaucoma	☐	☐	_____
Cataracts	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Disease	☐	☐	_____
Retinal Detachment	☐	☐	_____
Blindness (Complete Vision Loss)	☐	☐	_____
Lazy Eye	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Kidney Disease	☐	☐	_____
Thyroid Disease	☐	☐	_____
Cancer	☐	☐	_____

MILAM'S COMMUNITY EYE CARE
805A COMMERCE DRIVE · CONYERS, GA 30094 · 770-483-4831

RECEIPT OF NOTICE OF PRIVACY PRACTICES / RELEASE OD MEDICAL INFO
WRITTEN ACKNOWLEDGEMENT FORM / FINANCIAL POLICY

I, _____, have reviewed/received a copy of Milam's Community Eye Care's Notice of Privacy Practices.

INSURANCE BENEFITS:

_____ I authorize Milam's Community Eye Care to furnish information concerning my visit to my insurance carrier and assign to the provider all insurance payments for medical/vision services rendered on my behalf.

_____ I understand that verification of insurance eligibility and benefits is not a guarantee of payment, and that payment of insurance benefits is determined only when the claim is processed by the insurance carrier. I agree to assume financial responsibility for all co-pays, co-insurances, deductibles, denied, or non-covered services.

FINANCIAL RESPONSIBILITY:

_____ I understand all accounts are full responsibility of the patient and/or the patient's responsible party/guarantor. In case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection to this account to this account or future outstanding accounts.

_____ I consent to receiving emails, texts (SMS), auto-dialed and/or artificial or pre-recorded message to my cell phone or to any phone number or email provided by me to Milam's Community Eye Care or its affiliates and their agents including, without limitation, any account management companies and independent contractors including debt collectors. I understand that consenting is not required before I receive services from Milam's Community Eye Care.

Patient's Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Milam's
COMMUNITY EYE CARE
T.T. Underwood, Inc.
805-A Commerce Dr. Conyers, Georgia 30094
770-483-4831

**REGARDING VISIONCARE &
MEDICAL INSURANCE**

We often have patients that have both vision insurance (for example, VSP or EyeMed) and medical insurance (for example, Blue Cross, Aetna, Blue Shield, or Medicare). They are very different in terms of the services they cover, and it's important for our patients to understand these differences.

Vision insurance is designed mainly to cover determining a prescription for glasses, to help pay for glasses or contact lenses, and to cover a yearly routine evaluation of the health of the eyes in a healthy patient that has no particular problems or symptoms. It is not equipped to deal with and does not usually cover medical conditions, injuries, and/or treatments. **Medical insurance** is designed to cover you when you have a medical problem, including one that affects your eyes. Medical insurance does not cover routine services or examinations for glasses, or routine vision problems such as nearsightedness, farsightedness, and astigmatism. Those are only covered by your vision insurance.

When a medical diagnosis or medical condition is present that affects your eyes, such as high blood pressure, high cholesterol, or diabetes, to name just a few examples, or you have an eye disease or eye problem such as an infection (pink eye), dry eyes, allergy, or cataracts, again, just to name a few, we must file the claim with your **medical insurance**, and the co-pays and deductibles for that insurance will apply. Your vision plan does not cover these kinds of problems. Our office does not make these rules, they are made by the insurance companies themselves, and we must comply with them.

There is often no way to know prior to your examination which type of insurance will be the right one to file your claim with. We make every effort to join as many insurance panels, both medical and vision, as we can for your convenience. If we are on your insurance company's panel we will file those claims for you. In the event that we do not accept your medical or vision insurance we will provide you with an itemized receipt so that you may file a claim for reimbursement with your insurance company yourself. If you have any questions, please let us know.

I understand the information I've just read about the difference between vision and medical insurance. I authorize **MILAM'S COMMUNITY EYE CARE** to file my claim with the appropriate insurance based on the reason for my visit and the results of my examination.

Signed: _____

DATE: _____