DR. DAWN M. MILLER OPTOMETRIST

Time of arrival_____

Welcome to our office

(please print)

Patient's name Miss Ms. Mrs. Mr._____

Date of Birth_____ Age_____ SSN#xxx-xx-_____

If Child, name of Parent or Guardian_____

Home phone_____Daytime phone_____Cell phone_____ Ok to text? Yes No

Email_____ Ok to email? Yes No

Home Address_____

City_____Zip_____

No change to address
(please initial) ___

Primary vision insurance_____Primary health insurance_____

Occupation_____Employed by_____

Business Address_____Business phone_____

If married, name of spouse Miss Ms. Mrs. Mr._____

Spouse's Date of Birth_____ Spouse's Age_____ Spouse's SSN#xxx-xx-_____

Spouse's Occupation_____Spouse employed by_____

Spouse Business Address_____

Spouse's Cell phone_____ Spouse's Email_____

How did you find out about our office? (please circle if applicable)

VSP Vision care for life | MES Vision | yelp | Google+ | HEALTHGRADES GUIDING AMERICA TO BETTER HEALTHCARE

Friends/family:_____ Other:_____

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED. At least 50% deposit is required on all orders with the balance due on delivery. If your visit is covered by any type of private or union insurance, the office will be happy to complete the necessary insurance forms at a fee of $5.00. However, payment is expected from the patient as stated above with reimbursement from the insurance company going directly to the patient.

Signed_____ Date_____

Please flip over & fill out both sides…

DR. DAWN M.
MILLER
OPTOMETRIST

Please help us verify yearly…

Patient's name Miss Ms. Mrs. Mr._____ Date_____

Are you or anyone in your family currently being treated for or have a history of…….? (please circle)

Glaucoma	self	family	Diabetes	self	family
Cataracts	self	family	High Blood Pressure	self	family
Macular Degeneration	self	family	High Cholesterol	self	family
Crossed eyes	self	family	Heart problems	self	family
Retinopathy	self	family	Thyroid	self	family
Eye injuries	self	family	Cancer	self	family
Eye surgery	self	family	General surgery	self	family
Allergies	self	family	Asthma	self	family
Migraine	self	family	Sleep Apnea	self	family

Please list **ALL** medications you are taking and for what reason: _____
_____
_____

_____

Are you currently pregnant or breastfeeding? Yes No Have you ever had vision therapy/training? yes no

Have you ever worn (please circle) glasses contacts

How old are your present glasses? _____When do you wear them?_____

Are you having any problems with your current contacts?_____

Have you noticed any changes in your vision?_____

What is your reason for examination today? _____
_____

Date of last examination_____

Previous eye doctor (if not our office)_____

Primary health care provider_____

Please flip over & fill out both sides…