CENTRAL OHIO EYE PHYSICIANS & SURGEONS, INC.

262 Neil Ave. Ste. 420, Columbus, Ohio 43215 • (614)224-4297 1-800-537-2000

PATIENT'S NAME______________________________ MARITAL STATUS S M W D

DATE OF BIRTH______________ AGE_____ SEX_____ SOCIAL SECURITY #______________________

ADDRESS______________________________ HOME PHONE #______________

CITY______________________ STATE_____ ZIP CODE__________ WORK PHONE #______________

EMPLOYER______________________ OCCUPATION______________ CELL PHONE #______________

NAME OF SPOUSE OR (PARENT, IF PATIENT IS A CHILD)______________________________

FRIEND/RELATIVE FOR EMERGENCY CONTACT______________________ PHONE #______________

PLEASE DESCRIBE TYPE OF EYE PROBLEM YOU ARE HAVING______________________________

____

NAME & ADDRESS OF REFERRING DOCTOR

____

____

NAME & ADDRESS OF FAMILY DOCTOR

____

____

NAME/ADDRESS/PHONE # OF PREFERRED PHARMACY______________________________

DO YOU WEAR GLASSES? ( )yes ( )no

DO YOU WEAR CONTACT LENSES? ( )yes ( )no

PLEASE LIST ANY EYE INJURIES OR SURGERIES:

____

____

HAS ANYONE IN YOUR FAMILY HAD THE FOLLOWING CONDITIONS? ( )yes ( ) no. If yes, please check.
( )Cataract ( )Glaucoma ( )Macular Degen. ( )Crossed eyes

DO YOU SMOKE? ( )yes ( )no (How many?)__________

DO YOU DRINK ALCOHOL? ( )yes ( )no
If yes, how much______________________

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?
( )yes ( )no. If yes, please check. ( ) Heart Problems
( )Diabetes ( )High Blood Pressure ( )Breathing Problems
( )HIV ( )AIDS
Any other diseases:______________________

ARE YOU TAKING ANY MEDICATIONS?
( ) YES ( )NO If YES, please list:

Names & Dosages (how often)	(for office use) history reviewed-date

ALLERGIES TO ANY MEDICATIONS
( )YES ( )NO If YES, please list:

____

Recent surgeries:______________________

REFRACTIONS (A TEST USED TO EVALUATE AND OBTAIN YOUR BEST VISION) ARE USUALLY NOT COVERED BY MOST INSURANCE COMPANIES. THE PATIENT OUT-OF-POCKET RESPONSIBILITY FOR A REFRACTION IS $30.00. IF THERE ARE ANY OTHER CHARGES YOUR INSURANCE WILL NOT COVER, WE WILL ASK YOU TO SIGN A WAIVER FOR THESE SERVICES. AT THE TIME OF SERVICE WE WILL COLLECT THESE OUT-OF-POCKET FEES. Please sign and date below that you have read and understand these statements.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Central Ohio Eye Physicians and Surgeons, Inc. to furnish information to my insurance carriers and other Physicians and healthcare providers concerning my illness and treatments. I hereby assign to Central Ohio Eye and it's doctors all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance or authorized third party.

DATE______________ SIGNATURE______________________________