CENTRAL OHIO EYE PHYSICIANS AND SURGEONS

262 NEIL AVENUE, SUITE 420; COLUMBUS OH 43215 * TEL: 614-224-4297 * 1-800-537-2000 * FAX: 614-224-5668

PATIENT NAME	MARITAL STATUS S M W D
DATE OF BIRTH AGE SEX	SOCIAL SECURITY #
ADDRESS	HOME PHONE
	WORK PHONE
CITY STATE ZIP CODE	CELL PHONE
EMPLOYER	OCCUPATION

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

NAME OF FRIEND/RELATIVE FOR EMERGENCY CONTACT PHONE #

PLEASE DESCRIBE TYPE OF EYE PROBLEM YOU ARE HAVING

NAME/ADDRESS OF REFERRING DOCTOR

NAME/ADDRESS/PHONE # OF FAMILY DOCTOR

NAME/ADDRESS/PHONE # OF PREFERRED PHARMACY

DO YOU WEAR GLASSES? YES NO	DO YOU WEAR CONTACT LENSES: YES NO

LIST ANY EYE INJURIES OR SURGERIES (INCLUDING LASIK OR OTHER REFRACTIVE EYE SURGERY)

HAS ANYONE IN YOUR FAMILY HAD THE FOLLOWING CONDITIONS: YES NO

( ) CATARACT ( ) GLAUCOMA ( ) MACULAR DEGENERATION ( ) CROSSED EYES

DID YOU GET THE PNEUMONIA VACCINE? YES NO	DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS: YES NO	
DID YOU GET THE FLU SHOT? YES NO	**( ) HIGH BLOOD PRESSURE LAST READING**	( ) DIABETES LAST A1C
DO YOU SMOKE? YES NO HOW MUCH?	( ) HEART PROBLEMS	
DO YOU DRINK ALCOHOL: YES NO HOW MUCH?	( ) BREATHING PROBLEMS	
	( ) HIV	( ) AIDS
RECENT SURGERIES (PAST YEAR): YES NO	**ANY OTHER DISEASES**:	

ARE YOU TAKING ANY MEDICATIONS: YES NO IF YES, PLEASE LIST NAMES AND DOSAGE (OR PROVIDE A LIST)

ALLERGY TO MEDICATION: YES NO IF YES, PLEASE LIST (OR PROVIDE A LIST)

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 SERVCICE 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 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 its 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