CENTRAL OHIO EYE PHYSICIANS AND SURGEONS

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**_____ **SOCIALSECURITY#**_____

ADDRESS_____ **HOME PHONE #** _____

CITY_____ **STATE**_____ **ZIP**_____ **CELL PHONE #**_____

EMAIL ADDRESS: _____

EMPLOYER _____ OCCUPATION_____ WORK PHONE #_____

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

EMERGENCY CONTACT_____ PHONE#_____

PLEASE DESCRIBE TYPE OF EYE PROBLEM YOU ARE HAVING_____

_____

PLEASE LIST ANY EYE INJURIES, SURGERIES, LASIK, OR LASER: _____

_____

DO YOU WEAR GLASSES? ☐ YES ☐ NO **DO YOU WEAR CONTACT LENSES?** ☐ YES ☐ NO

PLEASE LIST MEDICATIONS

Name	Dosage	How Often	Name	Dosage	How Often

ALLERGIES TO ANY MEDICATIONS? ☐ NO ☐ YES: _____

NAME/ADDERSS/PHONE OF PREFERRED PHARMACY_____

HAS ANYONE IN YOUR FAMILY HAD THE FOLLOWING CONDITIONS? (PLEASE CHECK)
☐ CATARACT ☐ GLAUCOMA ☐ MACULAR DEGEN. ☐ CROSSED EYES.

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS? ☐ NO ☐ YES (If yes please check)
☐ **DIABETES** IF YES WHAT WAS YOUR LAST A1C? _____
☐ **HIGH BLOOD PRESSURE** IF YES LAST BP READING _____/_____
☐ **BREATHING PROBLEMS** ☐ **HEART PROBLEMS** ☐ **HIV** ☐ **AIDS**

LIST ANY OTHER DISEASES: _____

RECENT SURGERIES: _____

PLEASE SEE OTHER SIDE

DO YOU SMOKE? ☐ YES ☐ NO
If so, how many? _____

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO
If so, how much? _____

DID YOU GET A PNEUMONIA VACCINE? ☐ YES ☐ NO
DID YOU GET THE FLU SHOT? ☐ YES ☐ NO

NAME & ADRESS OF REFERRING DOCTOR

_____

_____

NAME/ADDRESS/PHONE OF FAMILY DOCTOR

_____

_____

PRIMARY INSURANCE PROVIDER: _____
SUBSCRIBER NAME: _____ DATE OF BIRTH: _____
SUBSCRIBER SSN: _____ MEMBER ID: _____

SECONDARY INSURANCE PROVIDER: _____
SUBSCRIBER NAME: _____ DATE OF BIRTH: _____
SUBSCRIBER SSN: _____ MEMBER ID: _____

DO YOU HAVE VISION INSURANCE? ☐ **YES** ☐ **NO**

VISION INSURANCE PROVIDER: _____
SUBSCRIBER NAME: _____ DATE OF BIRTH: _____
SUBSCRIBER SSN: _____ MEMBER ID: _____

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 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**_____