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:_____

THE $25.00 CHARGE FOR REFRACTIONS (a measurement used to evaluate your corrected vision) IS USUALLY NOT COVERED BY MOST INSURANCE COMPANIES. THIS CHARGE WILL BE YOUR RESPONSIBILITY. IF THERE ARE ANY OTHER CHARGES WE FEEL YOUR INSURANCE WILL NOT COVER, WE WILL ASK YOU TO SIGN A SEPARATE WAIVER FOR EACH SERVICE. Please sign and date below that you have read and understand this statement.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Central Ohio Eye Physicians and Surgeons, Inc. to furnish information to my insurance carriers and other physicians, concerning my illness and treatments and I hereby assign to the Physicians 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_____