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**_____