Columbus Eye Clinic &
Laser Surgery Center

Name_____
First Middle Last

Address: _____ City, State, & Zip_____

Gender: □ male □ female SS# _____-_____-_____ **Date of Birth** _____

Phone #'s (H) _____-_____-_____ (W) _____-_____-_____ (C) _____-_____-_____

Do you work □ yes □ no **Employers Name**: _____

Do you have internet access? □ Yes □ No Email Address: _____

In case of an emergency notify: _____ Phone # _____

Address _____ Relationship: _____

General Practitioner: _____ Referring Doctor: _____

Pharmacy Name/City _____ Phone #_____-_____-_____

Race: □ White □ Asian □ Black or African American □ Hispanic

□ Native Hawaiian or Pacific Islander □ American Indian or Alaskan Native

Ethnicity: □ NOT Hispanic or Latino □ Hispanic or Latino Preferred Language: _____

BILLING INFORMATION

Primary Insurance
Name of Insurance: _____

Contract #:_____ Group Name: _____ Group #:_____

Name of Policy Holder: _____

Policy Holder's Date of Birth _____ Relationship to Policy Holder: _____

Secondary Insurance

Name of Insurance: _____

Contract #:_____ Group Name: _____ Group #:_____

Name of Policy Holder: _____

Policy Holder's Date of Birth _____ Relationship to Policy Holder: _____

PLEASE SIGN RELEASE OF INFORMATION AUTHORIZATION ON BACK OF THIS FORM

COMPLETE THIS SECTION IF PATIENT IS A MINOR OR STUDENT

Person Responsible for Bill: _____

Father's Name _____

Address: _____Home Telephone _____

Employer: _____ Date of Birth _____

Occupation: _____Work Telephone _____

Mother's Name: _____

Address: _____Home Telephone _____

Employer: _____ Date of Birth _____

Occupation: _____Work Telephone _____

AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE COLUMBUS EYE CLINIC & LASER SURGERY CENTER ("Practice") TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR OTHER INSURANCE CARRIERS ANY MEDICAL OR OTHER INFROMATION. I UNDERSTAND THAT I AM RESPONSIBLE FOR FEES FOR MEDICAL SERVICES AND THAT INSURANCE IS FILED AS A COURTESY. I REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS BE MADE TO THE PARTY WHO ACCEPTS ASSIGNMENT. IN ASSIGNED CASES THE DOCTORS AGREE TO ACCEPT THE CHARGE OF DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE FOR COVERED SERVICES. THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE, AND NON COVERED SERVICES.

APPOINTMENT REMINDER POLICY

I authorize this Practice and their agent to place appointment reminder phone calls and mail post card reminders to the phone number and address I have listed on my patient form.

CONSENT TO TREATMENT

I authorize the physicians of the Practice, their associates, technical assistants and other health care providers under their direction to provide diagnostic evaluation and treatment. I understand that no guarantee has or will be made to me regarding any possible result or cure based on my examination and/or treatment.

Signature of Patient: _____ Date: _____

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MEDICAL AND OCULAR HISTORY QUESTIONNAIRE

Patient Name: _____ Gender ☐ Female ☐ Male Age: _____ Date: _____

Medical Doctor_____Address: _____

Please answer the following questions to the best of your ability. Give dates, a brief description, and which eye was involved to any **yes** question.

MEDICAL/SURGICAL HISTORY

Have you had any serious medical problems? ☐ No / ☐ Yes
(For example: heart, lung, kidney disease, high blood pressure or cancer) If yes please describe:

_____

_____

Do you have diabetes? ☐ No / ☐ Yes

How long have you had diabetes? _____

How often do you test your blood sugar? _____ Hemoglobin A1C? _____

How high was your blood sugar when last tested? _____

Have you ever been exposed to HIV or AIDS ☐ No / ☐ Yes

Are you HIV positive? ☐ No / ☐ Yes

If yes, CD4 count: _____ Date _____

Have you ever been hospitalized for any reason? ☐ No / ☐ Yes

If yes, please describe._____

_____

Have you had any major surgery? ☐ No / ☐ Yes

If yes, please describe._____

_____

Have you had any complications from anesthesia or bad reactions to medications? ☐ No / ☐ Yes

If yes, please describe._____

_____

Patient Name: _____ Date: _____

Please describe your current eye problem._____

_____

Have you ever had any eye disease, surgery, or injury in the past? ☐ No / ☐ Yes

If yes, please describe._____

_____

Does your vision make it difficult for you to function in activities of daily living? ☐ No / ☐ Yes

Please describe: _____

_____

_____

Do you smoke? ☐ No / ☐ Yes

FAMILY HISTORY

Is there any eye disease which runs in you family? ☐ No / ☐ Yes

(for example: glaucoma, retinal detachment or macular degeneration)

If yes, please describe. _____

Has any member of your family lost vision for any reason? ☐ No / ☐ Yes

If yes, please describe. _____

Is there any significant medical disease which runs in your family? ☐ No / ☐ Yes

(for example: heart, long, or kidney disease, high blood pressure or cancer)

If yes, please describe. _____

Please list any medication(s) including eye drops, which you are taking.

Name of Medication	Amount Taken	Times Taken	Comment

Patient Name:_____ Date: _____

REVIEW OF SYSTEMS Do you currently have...

CARDIOVASCULAR:

Chest pain?	❑ No	❑ Yes
Enlarged heart?	❑ No	❑ Yes
Heart disease?	❑ No	❑ Yes
Heart murmur?	❑ No	❑ Yes
Irregular heart beat?	❑ No	❑ Yes
Shortness of breath?	❑ No	❑ Yes
Swelling of feet?	❑ No	❑ Yes
Blood Clots?	❑ No	❑ Yes
High blood pressure?	❑ No	❑ Yes
High Cholesterol?	❑ No	❑ Yes
Pace Maker?	❑ No	❑ Yes
Defibrillator?	❑ No	❑ Yes

HEMATOLOGY:

Anemia?	❑ No	❑ Yes
Bleeding disease?	❑ No	❑ Yes
Sickle Cell disease?	❑ No	❑ Yes

NEUROLOGY:

Stroke?	❑ No	❑ Yes
Seizures?	❑ No	❑ Yes
Paralysis?	❑ No	❑ Yes
Dizziness?	❑ No	❑ Yes
Double vision?	❑ No	❑ Yes
Multiple Sclerosis?	❑ No	❑ Yes

GENITOURINARY:

Kidney trouble?	❑ No	❑ Yes
Urine problem?	❑ No	❑ Yes
Gonorrhea?	❑ No	❑ Yes
Syphilis?	❑ No	❑ Yes
Other?	❑ No	❑ Yes

PULMONARY:

Asthma?	❑ No	❑ Yes
Emphysema?	❑ No	❑ Yes
Cough?	❑ No	❑ Yes
Lung disease?	❑ No	❑ Yes
Pneumonia?	❑ No	❑ Yes
T.B.?	❑ No	❑ Yes
Wheezing?	❑ No	❑ Yes
Bronchitis?	❑ No	❑ Yes

ENDOCRINE:

Thyroid disease?	❑ No	❑ Yes
Diabetes?	❑ No	❑ Yes
Diabetic Neuropathy	❑ No	❑ Yes
Diabetic Foot ulcers	❑ No	❑ Yes
Diabetic Kidney Failure	❑ No	❑ Yes

PSYCHIATRY:

Depression?	❑ No	❑ Yes
Other disorders?	❑ No	❑ Yes

GASTROENTEROLOGY:

Stomach trouble?	❑ No	❑ Yes
Trouble with intestines?	❑ No	❑ Yes
Hepatitis?	❑ No	❑ Yes
Porphyria?	❑ No	❑ Yes

REPRODUCTIVE:

Are you pregnant?	❑ No	❑ Yes

Date of last menstrual period: _____

RHEUMATOLOGY:

Trouble with your joints?	❑ No	❑ Yes
Back trouble?	❑ No	❑ Yes
Lyme disease?	❑ No	❑ Yes
Sarcoidosis?	❑ No	❑ Yes
Any other inflammatory disorders	❑ No	❑ Yes

Describe: _____

Please describe your current eye problem.

OCULAR HISTORY

Have you ever had any eye disease, surgery, or injury in the past? ❑ No / ❑ Yes

If yes, please describe. Include dates and the name of the doctor who treated you.

Doctor	Date	Describe	Which Eye

Did any previous eye disorder result in loss of vision? ❑ No / ❑ Yes

If yes, please describe.

Have you ever been told you have amblyopia or "lazy eye"? ❑ No / ❑ Yes

THIS SPACE RESERVED FOR PHYSICIAN ONLY

Chief Complaint:

Reason for Consultation:

History of Present Illness: (Location, Quality, Severity, Duration, Context, Modifying Factors, Timing)

Orientation to time, place & person: ❑ Normal ❑ Other:

Mood/affect: ❑ Normal ❑ Other:

Physician's Signature: Tech. Signature: Date: