OPHTHALMIC SURGEONS & CONSULTANTS OF OHIO, INC.

262 NEIL AVENUE, SUITE 4-430
COLUMBUS, OHIO 43215
(614) 221-7464 • (800) 964-9969

Patient's Name: _____ Sex: _____ Race: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Home Ph: (____) _____ Cell Ph: (____) _____

Birth Date: _____ Age: _____ Social Security No: _____

Marital Status: (circle) M S W D Spouse's Name: _____

Spouse's Social Security No: _____ Spouse's Birth Date: _____

Responsible Party (if different than patient or spouse): _____

Address: _____ City / State / Zip: _____

Social Security No: _____ Birth Date: _____ Relationship to patient: _____

Responsible Party Home Ph: (____) _____ Cell Ph: (____) _____

If Referred by Another Physician— Physician Name: _____

Address: _____ City / State / Zip: _____

Phone: (____) _____

Primary Care Physician (if different from referring Physician): _____

Address: _____ City / State / Zip: _____

Phone: (____) _____

Primary Insurance Company

Name: _____

Address: _____

City/State/Zip: _____

ID Number: _____

Subscriber: _____

Secondary Insurance Company

Name: _____

Address: _____

City/State/Zip: _____

ID Number: _____

Subscriber: _____

Patient's Employer (or retired from): _____

Address: _____ City / State / Zip: _____

Work Phone: (____) _____

Spouse's (or Responsible Party's) Employer (or retired from): _____

Address: _____ City / State / Zip: _____

Work Phone: (____) _____

Emergency Contact: _____ Relationship: _____

Address: _____ City/State/Zip: _____

Phone: (____) _____ Cell Phone: _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION BY OPHTHALMIC SURGEONS & CONSULTANTS OF OHIO, INC. FOR ANY INSURANCE CLAIMS SUBMISSION AND AT THE DOCTOR'S DISCRETION, ASSIGN THE INSURANCE PAYMENT TO THEM FOR THESE SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES THAT ARE NOT COVERED.

PATIENT OR RESPONSIBLE PARTY SIGNATURE: X _____

DATE: _____

Have you been hospitalized in the last 5 years? _____ If so, for what? _____

_____

_____

DO YOU HAVE OR HAVE YOU HAD:

	YES	NO
Anemia	_____	_____
Diabetes	_____	_____
Epilepsy	_____	_____
Hepatitis	_____	_____
Rheumatic Fever	_____	_____
Heart Murmur	_____	_____
Abnormal Heart Condition	_____	_____
Abnormal Bleeding from a Cut	_____	_____
Abnormal Blood Pressure	_____	_____
S____ /____ /____	_____	_____

ARE YOU ALLERGIC TO:

Penicillin	_____	_____
Local Anesthetic	_____	_____
Medication or Drugs	_____	_____
Women, are you pregnant?	_____	_____

If allergic to medications or drugs, indicate which ones _____

_____

Are you taking any medication? _____ If so, for what _____

_____

Other Physical Conditions _____

_____

Eye History _____

_____

Family History _____

_____

Are you receiving other health care? _____ If so, please indicate the nature of the care _____

_____

_____

_____

_____

Name of the other doctor _____

Address _____ City/State/Zip _____

Phone (____) _____