COMPREHENSIVE EYECARE OF CENTRAL OHIO

CompEyeCare.com
(614) 890-5692 • Fax (614) 890-5629
450 Alkyre Run Drive, Suite 100 • Westerville, OH 43082

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____

DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Social Security Number: _____

Occupation: _____

Employer: _____ Work Phone: _____

Spouse: _____ Spouse's Phone: _____

Family Physician: _____ Phone: _____

Pharmacy (Local) Address/Phone: _____

Pharmacy (Mail Order): _____

PRIMARY LANGUAGE

❍ English ❍ Spanish ❍ Somali ❍ American Sign Language ❍ Other: _____

RACE

❍ American Indian/Alaskan ❍ Native Hawaiian or Pacific Islander ❍ African American

❍ White ❍ Asian ❍ Decline to Specify ❍ Other: _____

ETHNICITY

❍ Hispanic or Latino ❍ Not Hispanic or Latino ❍ Decline to Specify

REASON FOR CONSULTING OUR PRACTICE

❍ Doctor Referral (Name):_____Dr. Address_____

❍ Family/Friend (Name):_____ ❍ ER/Urgent Care: _____

❍ Columbus Yellow Pages ❍ Delaware County Yellow Pages ❍ Insurance

PERSON RESPONSIBLE FOR BILL *(other than yourself)*

First Name: _____ Last Name: _____

Relationship: _____Phone:_____

Address: _____

City: _____ State: _____ Zip Code: _____

EMERGENCY CONTACT

First Name: _____ Last Name: _____

Relationship: _____Phone: _____

VISION COVERAGE

❍ VSP ❍ EYEMED ❍ Self-Pay

PRIMARY INSURANCE INFORMATION

Plan: _____

Policy Holder: _____ Relationship: _____

Policy Holder SS#:_____ Policy Holder DOB: _____

SECONDARY INSURANCE INFORMATION

Plan: _____

Policy Holder: _____Relationship:_____

Policy Holder SS#:_____ Policy Holder DOB: _____

FINANCIAL POLICY: By my signature below, I indicate that I understand that I am ultimately responsible for payment of my bill. Comprehensive EyeCare of Central Ohio (CECCO) will send my claim to the insurance company that I present at the time of the visit and will accept assignment on the plans that they are participating with. CECCO will send a claim, upon request, on my behalf, to insurances they are not participating with; I am however responsible for the full payment of the bill.

Co-pays and deductible are also due at the time of service.

ASSIGNMENT OF BENEFITS: I request that payment of authorized Medicare benefits and/or payment from my current insurance carrier/supplemental insurance be made on my behalf to CECCO for any service furnished to me. I further authorize the release of pertinent information needed to determine these benefits or the benefits payable for related services, to the Health Care Financing Administration and/or insurance carrier/supplemental insurance carrier as its agents.

NOTICE OF PRIVACY PRACTICES: I acknowledge I have been offered/received a Notice of Privacy Practices.

Sign: _____ Date: _____

Limited Patient Authorization for Disclosure of Protected Health Information **Form 7.31**
Please print all information. Form must be signed and dated each year.

Patient Name: _____
SSN: (last four digits): _____ **Date of Birth:** _____
Entity Requested to Release Information: Comprehensive EyeCare of Central Ohio_____

Purpose of request (who will be authorized to receive information) – I authorize the entity identified above to disclose or provide protected health information, about me to the individual listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI):
Individual/Entity Name: _____
Address: _____
Phone/Fax: _____/_____
Email *: _____
***Secure Communication** – Note that some fax and email transmission methods are not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate fax or email as your preferred method of disclosure if this is of concern to you.

Description of information to be disclosed – I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

☐ Office notes
☐ Lab results, pathology reports
☐ x-rays
☐ financial history report (previous 3 years only)
☐ nursing home, home health, hospice, and other physician records
☐ record of HIV and communicable disease testing
☐ record of mental health or substance abuse treatment
☐ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):
☐ Patient Request
☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year of your last signature below unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

_____
Patient or authorized representative signature date

_____
Patient or authorized representative signature date

You have the right to receive a copy of signed authorizations upon request.

MEDICAL HISTORY QUESTIONNAIRE

A THOROUGH MEDICAL HISTORY IS ESSENTIAL BECAUSE:

- It helps the physician/surgeon to **DETERMINE YOUR CURRENT HEALTH PROBLEMS**.
- It tells the physician/surgeon what **RISKS YOU MAY FACE IN THE FUTURE**.
- It allows the physician/surgeon to **PROVIDE THE MOST EFFECTIVE AND APPROPRIATE TREATMENT**.
- It personalizes treatment options to **MEET YOUR SPECIFIC NEEDS**.

Current date_____/_____/_____

Patient name _____

DOB: _____/_____/_____

Primary Care Physician _____

Previous ophthalmologist/optometrist: Y_____N

What condition were they managing? _____

Name of doctor: _____

Date of last visit: _____

Were you referred by another physician? Y_____N

Reason for referral: _____

Referring doctor: _____

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MEDICATIONS

Please list ALL medications – Rx and OTC.

Medication name	Strength	Frequency

Do you take a diuretic? **(ex: Hydrochlorothiazide/HCTZ, Chlorthalidone, etc)** **Y N**

Do you take Plaquenil? **(Generic: Hydroxychloroquine)** **Y N** **Start Date:** _____

Drug Allergies

Please **circle medication** and **record the reaction** you experienced

	Reaction	
Beta Blockers	_____	Other: _____
Latex	_____	_____
Local anesthetic	_____	_____
NSAIDS (Aspirin, Ibuprofen etc)	_____	_____
Penicillin	_____	_____
Sulfonamides	_____	
Tetracyclines	_____	

Ocular History

Blepharitis/Styes	Y	N	Keratoconus	Y	N
Cataracts	Y	N	Glaucoma	Y	N
Contact Lenses or Glasses	Y	N	Lazy Eye / Strabismus	Y	N
Scleral or RGP contact lenses	Y	N	Macular Degeneration	Y	N
Diabetic Retinopathy	Y	N	Corneal disease/condition	Y	N
Dry Eye	Y	N	Retinal Disease/condition	Y	N
Flashes/Floaters	Y	N	Shingles or HSV	Y	N

History of refractive surgery Y N

Date:_____

Type: **RK PRK LASIK LASEK ICL**

Surgeon:_____

Other:_____

_____

_____

_____

Personal Medical History

Alzheimer's Disease	Y	N	Epilepsy /Seizure Disorder	Y	N
Anxiety	Y	N	Hearing Loss	Y	N
Arthritis	Y	N	Heart Disease	Y	N
Asthma	Y	N	High Blood Pressure	Y	N
Atrial Fibrillation	Y	N	High Cholesterol	Y	N
Autoimmune Disease	Y	N	Kidney Disease-**NO DIALYSIS**	Y	N
Blood clots (DVT)	Y	N	Kidney Disease- **W/DIALYSIS**	Y	N
Blood Disorder	Y	N	Multiple Sclerosis	Y	N
Bell's Palsy	Y	N	Migraines (with or w/o aura)	Y	N
Cancer	Y	N	Myasthenia Gravis	Y	N
Chronic Sinusitis	Y	N	Parkinson's Disease	Y	N
COPD	Y	N	Prostate Disorder	Y	N
Congestive heart failure	Y	N	Rheumatoid Arthritis	Y	N
Dementia	Y	N	STD Diagnosis (Type)_____	Y	N
Depression/Mood Disorder	Y	N	Sjogren Syndrome	Y	N
Diabetes: **Type I / Type II**	Y	N	Skin Condition(s)	Y	N
Ehlers-Danlos Syndrome	Y	N	Stroke (Date?)_____	Y	N
			Thyroid Disorder: **Hyper / Hypo**	Y	N

Other:_____

_____

_____

Family Medical History (BLOOD RELATIVE)

Heart disease	Y	N	High blood pressure	Y	N
Autoimmune Disorder(s)	Y	N	Stroke (CVA)	Y	N
Arthritis	Y	N	Cancer	Y	N
High Cholesterol	Y	N	Thyroid Disorder: **Hyper / Hypo**	Y	N
Diabetes: **Type I / Type II**	Y	N	Migraines w/or without aura	Y	N
Glaucoma	Y	N	Macular Degeneration	Y	N
Keratoconus	Y	N	Sjogren Syndrome	Y	N

Surgical History

Please list **ALL** surgeries or operations you have undergone, including medical and ocular

Surgery/Operation/Procedure	Date	Surgeon
• _____	_____	_____
• _____	_____	_____
• _____	_____	_____
• _____	_____	_____
• _____	_____	_____
• _____	_____	_____
• _____	_____	_____
• _____	_____	_____
• _____	_____	_____
• _____	_____	_____

Social History

Do you smoke? **Y N** **Daily ___ Occasionally ___ Socially___How many years? ___**

Former smoker? **Y N** **Year you quit _____**

Drink Alcohol? **Y N** **Never _____ Daily _____ Weekly _____ Socially _____**