Welcome to Our Office

Columbiana Vision Care

Name: _____ Date: _____/_____/_____

Date of Birth: _____/_____/_____ ☐ Male ☐ Female

Address: _____ City: _____ Zip: _____

Home Phone: (_____)_____ Cell: (_____)_____ Pref: ☐ Home ☐ Cell

Email: _____ SS# (age 21&over): _____-_____-_____

Insurance (vision/medical): _____

Employer: _____ Occupation: _____

History

Who is your Primary Care Physician? _____

If you are new to our office, when was your last eye exam? _____

Do you wear ☐ glasses / ☐ contact lenses?

Contact Brand: _____ ☐ Daily ☐ 2 week ☐ Monthly ☐ Annually

Please check all that apply to you:

Eye Injuries/Surgeries	☐	Cancer _____	☐	Intestinal/Stomach Problems	☐
Blindness	☐	Stroke	☐	Arthritis/Joint Pain	☐
Turned/Lazy Eye	☐	Heart Disease	☐	Neurological Disorder/Paralysis	☐
Cornea Problems	☐	High Blood Pressure	☐	Skin Disorder	☐
Diabetes	☐	High Cholesterol	☐	HIV/AIDS/Blood Disorder	☐
Smoker	☐	Hypo/Hyper Thyroid	☐	Asthma/Chronic Cough	☐
Drink Alcohol	☐	Anxiety/Depression	☐	Sinus Problems	☐

Cataracts	☐ Self	☐ Parents	☐ Siblings
Glaucoma	☐ Self	☐ Parents	☐ Siblings
Retinal Problems	☐ Self	☐ Parents	☐ Siblings
Macular Degeneration	☐ Self	☐ Parents	☐ Siblings
Diabetic Retinopathy	☐ Self	☐ Parents	☐ Siblings

Please list all MEDICATIONS / SUPPLEMENTS: (**or** we will be happy to copy your current list)

_____ _____

_____ _____

_____ _____

_____ _____

Please Fill Out Both Sides > OVER

Please list all ALLERGIES/DRUG ALLERGIES:

_____ _____

_____ _____

_____ _____

Are you experiencing any of the following eye symptoms?

Blurred/loss of vision	☐	Eye pain	☐
Floaters/spots	☐	Burning/Itching	☐
Flashing lights	☐	Discharge/excess tearing	☐
Light sensitivity	☐	Eye strain	☐
Double vision	☐	Redness	☐
Headaches	☐	Dry/gritty eyes	☐
Poor distance vision	☐	Stye/Chalazion	☐
Poor near vision	☐	Other _____	

Policy & Authorization:

Thank you for entrusting the care of your eyes to us. We provide 24 hour access for all eye related problems, including infections, foreign body removals, and glaucoma treatment. Please do not hesitate to ask for assistance if you have any questions or concerns.

Insurance co-pays will collected on the date of service. If you are not able to pay your co-payment today, please reschedule your appointment. For your convenience, our office accepts cash, checks, and debit/credit cards, including CareCredit and American Express.

Our office reserves the right to collect in full for services rendered on the date of service and thereafter, if there's a lapse in coverage and/or termination of the plan. Private pay (no insurance) must pay in full for exam on date of service and make a deposit on any materials ordered. Our returned check fee is $30.00.

If after 90 days, we have not received payment from your insurance company, our office reserves the right to send the entire bill to the patient for payment. It will be your responsibility at that point to contact your insurance company with any questions or concerns regarding your bill. It is your responsibility to know the special terms, deductibles, and/or co-pays of your insurance coverage. Your insurance carrier cannot be billed unless you provide necessary documentation. Please remember your insurance policy is between you and your insurance company and not with the insurance company and your doctor.

The intention of this notice is to clarify our office policies and procedures and promote good communication between our patients and our office.

I certify that I have read and understood the above information and have answered all questions accurately to the best of my knowledge. I authorize my eye doctor to release any information including the diagnosis and the records of any examination or treatment rendered to me or my dependent during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to my eye doctor and assume responsibility for all charges that may not be covered.

Patient (or responsible party) Sign: _____

Date: _____/_____/_____