



Welcome to

COLUMBUS EYEWORKS

CLEAR VISION BEGINS WITH HEALTHY EYES

www.columbuseyeworks.com

Patient Information

Thank you for choosing our practice for your eyecare needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____
Dr./Master/Miss/Mr./Mrs./Ms. First MI Last
Address _____ Apt. # _____
City _____ State _____ Zip _____
Home phone # _____ Work phone # _____ Alt. phone # _____
Do you prefer to receive calls at: Home Work Alternate Any
Social Security # _____ Birthdate _____ E-mail _____
Are you: Minor Married Widowed Single Partnered
Your employer _____ Occupation _____
Business Address _____ City _____ State _____ Zip _____
If you are a student, name of school/college _____ City _____ State _____
Spouse's/partner's name _____ Workplace _____
Work phone # _____ Spouse's/partner's social security # _____
Minor children's names _____
Would you like us to set up appointments for any family members: Yes No
Person to contact in case of emergency _____ Phone # _____
Whom may we thank for referring you to us? _____
If you were not referred, how did you hear about Columbus Eyeworks? _____

Responsible Party

(If Different From Patient)

Name of person responsible for this account? _____
Relationship to patient _____ Home phone # _____
Address _____ City _____ State _____ Zip _____
Social Security # _____ Birthdate _____
Name of employer _____ Work phone # _____

Insurance Information

(Office Use Only)

PLEASE COMPLETE REVERSE

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Health History

Name _____ Age _____

Reason for today's exam _____

Date of last eye exam _____ Name of eye doctor _____

Date of last physical exam _____ Name of medical doctor _____

Do you or anyone in your immediate family have a history of the following?

- Diabetes Blindness High blood pressure Arthritis Stroke
- Cataracts Thyroid Turned or lazy eye Lupus Macular Degeneration
- Glaucoma Heart condition Respiratory problems Cancer

Please check any of the following conditions that apply to you:

- Frequent headaches Allergies Sinus trouble Have given birth in the last six months
- Head injury Drug allergies Pregnant HIV +

Please list all medications, vitamins, or herbal supplements you are currently taking: _____

Please list any medications you are allergic to: _____

Do you use tobacco products? Yes No

Have you ever had any of the following conditions involving your eyes?

- Eye surgery Sensitivity to light Eye infection or disease Difficulty driving at night
- Eye injury Floaters or spots Double vision Retinal detachment
- Medical treatment Poor distance vision Eye strain Transient loss of vision
- Severe pain Poor near vision Eyes burn, itch, or water Dry Eyes

Do you currently wear glasses? Yes No

When do you wear your glasses?

- All the time Reading/near work Other, please explain _____
- Work safety Distance tasks only
- Computer work Sports

Have you ever worn contacts? Yes No

Are you interested in wearing contact lenses? Yes No

If so, what style?

- Soft Extended Wear Gas Permeable Bifocal
- Tinted Astigmatic Disposable Unsure

Do you work at a computer or video display terminal? Yes No

If so, do you use specific PRIO/computer glasses? Yes No

Are you interested in laser vision correction? Yes No

What hobbies or sports do you participate in? _____

(Warning - Polycarbonate lenses are the most break resistant lenses and offer the best protection against eye injury and possible permanent reduction in vision for patients of any age.)

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

SIGNATURE OF PATIENT (Or parent if a minor)

DATE

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