Dr. Christine Beiling
Dr. Timothy Earley
Dr. Jessica Simon
Dr. Sandra Travaglianti
Optometrists

4463 Weymouth Road
Medina, Ohio 44256

Phone: (330) 722-2150
Fax: (330) 722-2055

Medina Vision and Laser Centre

Patient Information

(Note: Please fill in ALL of the information or mark N/A – Use Black Ink)

First Name: ____________________ Middle Initial: ______ Last Name: ______________________________
Street: ______________________________ City: ____________________ State: __________ ZIP_______
Date of Birth: ________________ Sex: M / F Social Security #: ______________ Marital Status: S M D W
Phone #'s: Home: (____) ____ - _______ Work / Daytime: (____) ____ - _______ Cell: (____) ____ - _________

PLEASE INDICATE YOUR PREFERRED COMMUNICATION FOR REMINDERS AND EYEWEAR NOTIFICATIONS (Circle)

Voice Message via Home Phone **Text Message Via Cell Phone** **Email**

Email Address: ____________________________ Race: ____________ Ethnicity: Non-Hispanic/Hispanic Latino/Other
Employer / School: __________________________ Occupation / Teacher: ____________________
Employment Status: Full Time Part Time Retired Student **Reason For Visit**: ____________________
Names of Family Member in Household: ____
Were you referred by another Doctor / Patient? If so, name please: ______________________________

Insurance Information

VISION Coverage: YES / NO Insurance Co. Name (if no, pls initial): ______________________________
Policy Holder's Name: ______________________________ Relationship to Patient: ______________
Policy Holder Date of Birth: ____________ Social Security #: ______________ Phone: ______________
Policy Holder Address (if different than above): ____
Policy Holder Employer: ____

Medical Coverage: YES / No Insurance Co. Name: ____
Policy Holder's Name: ________________________ Relationship to patient: ______________
Policy Holder Date of Birth: ____________ Social Security #: ______________ Phone: ______________
Policy Holder Address (if different than above): ____
Policy Holder Employer: ________________________

BILLING INFORMATION (After Insurance):
Send Bills to Name: ______________________________ Relationship to Patient: ______________
Address: ____

SIGNATURE ON FILE – PLEASE READ CAREFULLY!

I authorize the use of this form on all my insurance submissions. I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. ***I understand I am responsible for any referrals required by my insurance.*** *I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I authorize payment directly to my doctor.* ***INSURANCE COPYAS ARE DUE AT THE TIME OF SERVICE!*** *OPTOS Retinal Scans are an optional test recommended for retinal health and analysis. This test is typically* ***NOT*** *covered by insurance.* ***MEDICARE PATIENTS:*** *In addition to the above statement, I understand Medina Vision Centre has agreed to accept the charge determination for Medicare-assigned cases as the full charge and I as the patient am only responsible for the deductible, co-insurance and non-covered services. I hereby state that the above information I have provided is correct to the best of my knowledge.*

I have been provided with and understand the Billing Policy Statement

______________________________________ ______________

Signature of Patient or Responsible Party ***Date***

Continued on BACK, Please turn over -→

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OCULAR & MEDICAL HISTORY

Have you ever had any of the following: (Please check all that apply)

___ Corneal Problems
___ Cataracts
___ Retinal Problems
___ Glaucoma
___ Amblyopia (Lazy Eye)
___ Double Vision/Strabismus Problems
___ Dry Eye
___ Injuries/Trauma to Eyes

Do you currently wear contacts? Yes No If Yes, What type?: Soft Gas Perm CRT Scleral
Have you ever had Lasik or PRK Surgery? Yes No If Yes, When?: ______________________

Do you currently have or previously had any of the following conditions?: (Please check all that apply)

___ Diabetes Last A1-C#__________
___ lupus
___ Rheumatoid Arthritis
___ HIV / AIDS
___ Hepatitis
___ Heart Problems
___ Hypertension
___ Asthma (Current / Previous)
___ Sleep Apnea / CPAP
___ Cancer (Current / Previous)
___ History of Stroke
___ Kidney / Liver problems
___ Thyroid problems
___ Currently Pregnant / Breast Feeding
___ Tobacco Use ____________ (Cigarette / Chew)
___ Consume Alcohol? ______ Drinks per (WK / Day)
___ Any Medical Condition Not Listed Above*

Please write any medical condition not listed above: ______________________________
____

Current Height : __________ Current Weight: __________ (Required by most insurance companies. Thank you!)

Medical or Environmental Allergies: **DO NOT LEAVE BLANK, PUT "NONE" IF NONE**
____
____

Medications, vitamins & supplements and the dosage you are currently taking: **DO NOT LEAVE BLANK, PUT "NONE" IF NONE**
____
____
____

Primary Care Physician / Specialist: ______________________________
Address & Phone #: ______________________________
Pharmacy Name & Location: ______________________________

IN CASE OF EMERGENCY: Name: ______________ Phone#:__________ Relation:__________

Family History

Does anyone in your family have any of the following conditions?: (Check all that apply)

___ Glaucoma ___ Cataracts ___ Keratoconus ___ Retinal problems / Macular Degeneration