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

Medina Vision and Laser Centre

4463 Weymouth Road
Medina, Ohio 44256

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

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

○ **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, Vision/Medical Visit Info. Sheet & the Patient Acknowledgment of Financial Responsibility sheet. Completing the signature field with name will constitute replacement of written signature.

_____ _____

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