

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



4463 Weymouth Road
Medina, Ohio 44256

Medina Vision and Laser Centre

Patient Information

Phone: (330) 722-2150

Fax: (330) 722-2055

(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 ->



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



Medina Vision and Laser Centre

Patient Information

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

4463 Weymouth Road
Medina, Ohio 44256

Phone: (330) 722-2150

Fax: (330) 722-2055

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

Have you been vaccinated for Covid-19? yes no
Have you tested positive for Covid-19? yes no If so, when _____

