Ted M. Smiley, O.D., Patrick Dollenmayer, O.D.

Welcome to our office! Please aid us in providing us with the most comprehensive eyecare possible.

Name:_____ Nickname:_____ M____ F____ Date of Birth: ____/____/____

Current Address: _____City: _____ Zip:_____

Home Phone: _____ Work Phone:_____ Cell Phone:_____

Please Circle Preferred Contact Number

Email: _____

Patient's Occupation: _____ Patient's Employer: _____

Financially Responsible (if minor) _____ Address: _____

Current Medical Insurance:_____ ID#: _____

Please Present Medical Insurance Card

S.S. #: _____ Other household members who are patients here: _____

Whom may we thank for referring you to our office? _____

Current Vision Insurance:_____ ID#: _____

Health History

What is your reason for coming in today? _____

Do you wear contact lenses? ____ If so, what type? _____ Are you interested in Contact Lenses today?_____

Are you interested in discussing refractive surgery? ____ Date of Last Eye Examination (if not in our office): ___/___/___

Patient Eye History: Have you had the following eye problem/disease? (Please **CHECK ALL** that apply.)

Crossed eyes: ____ Lazy Eye: ____ Need for eye patching: ____ Need for eyeglasses: ____ Cataract: ____

Eye injury: ____ Glaucoma: ____ Macular Degeneration: ____ Retinal Detachment: ____ Eye Surgery: ____

Social History: (please answer yes or no)

Do you smoke? _____If yes, how long? _____ Do you drink alcohol? _____ Do you drink caffeine? _____

Medications: (please list **ALL** medications you are taking or provide a list to be copied): _____

_____

Allergies: (please list **ALL** allergies, including, drugs, food, adhesives, etc.) _____

_____

***** OVER*****

Review of System: Have you had the following? (Please **CHECK ALL** that apply.)

____ Do you have a history of bleeding problems or blood disorders?
____ Are you taking Blood thinners?
____Have you had any problems from general anesthesia?
____ Have you taken cortisone or steroids?
____ Do you use Aspirin regularly?
____ Do you take birth control pills?
____Are you pregnant? If so, how many weeks? _____
____ Are you nursing an infant?

Patient Health History: Have you had the following? (Please **CHECK ALL** that apply.)

____ Diabetes	____ Recent unexplained weight loss, fever, chills	____ Asthma or breathing problems
____ High blood pressure	____ History of nausea, vomiting, prolonged dizziness	____ Immuno- deficient disease
____ Stroke	____ Weakness, numbness, or balance problems	____ Thyroid disease
____ Lung Disorders `	____ Hearing Problems, sinus problems	____ Liver or Kidney trouble
____ Cancer	____ Chemotherapy/ radiation therapy	____ Sexually transmitted disease
____ Arthritis	____ Joint pain and/or swelling	____ Rashes or skin problems
____ Urinary problems	____ Ulcers, diarrhea, digestive problems	____ Psychiatric disorders

Family History: (Please **CHECK ALL** that apply.)

____ Glaucoma	____ Cataract	____ Eye turns out /in	____ Blindness
____ Diabetes	____ Arthritis	____ High blood pressure	____ Macular degeneration
____ Heart Problems	____ Cancer	____ Color Blindness	____ Bleeding/ blood disorders

Your last complete medical examination or physical… Date: ____/_____ Family Doctor: _____

Address: _____ Phone Number: _____

Your last complete eye examination… Date: ____/_____ Optometrist: _____

Address: _____ Phone Number: _____

With my signature I accept full responsibility of any fees incurred for services provided by Columbus Eyecare Associates that are not covered by my insurance company. If spectacles or contact lenses are to be ordered, a 50% deposit is required. Any balance owed is due in full prior to materials being delivered to me. It will be my responsibility to collect insurance reimbursement if my vision plan does not list Columbus Eyecare Associates as preferred providers, and I will pay as services are rendered. With my signature below I acknowledge that I have received a copy of the Columbus Eyecare Associate, Inc. privacy practices.

Patient Signature (Responsible party if minor): _____ Date: ____/_____/_____