Ophthalmic Surgeons & Consultants of Ohio 262 Neil Avenue, Suite 430 • Columbus, OH 43215
614 221.7464 phone • 800 964.9969 toll-free

Patient Information *(please print — use black ink only)*

Patient Name: (Last) _____ (MI) _____ (First) _____

Street Address: _____ E-mail: _____

City: _____ State: _____ Zip Code: _____

Home Ph: (____) _____ - _____ Work Ph: (____) _____ - _____ Cell Ph: (____) _____ - _____

Birth Date: ____ / ____ / ____ Age: _____ SS#: _____ - ____ - _____ ☐M ☐F Race _____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated Spouse's Name: _____

Emergency Contact, other than Spouse *(not living with you)*

Name: _____

Home Ph: (____) _____ - _____ Work Ph: (____) _____ - _____ Cell Ph: (____) _____ - _____

Relationship to Patient: _____

Referring Physicians

Who may we thank for referring you to our office?: _____

Referring Physician: _____ Office Phone: (____) _____ - _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Care Physician: _____ Office Phone: (____) _____ - _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Employment

Patient's Employer (or retired from): _____

Street Address: _____ Work Ph: (____) _____ - _____

City: _____ State: _____ Zip Code: _____

Spouse's Employer (or retired from): _____

Street Address: _____ Work Ph: (____) _____ - _____

City: _____ State: _____ Zip Code: _____

OVER ⇨

INSURANCE COVERAGE

Please provide your insurance and I.D. cards for photocopying.
If this form is not filled out in its entirety, you may be responsible for payment of services.

Responsible Party (if different than patient or spouse): _____

Address: _____ City / State / Zip: _____

Social Security No: _____ Birth Date: _____ Relationship to patient: _____

Responsible Party Home Ph: (_____) _____ Cell Ph: (_____) _____

Primary:

Insurance
Company Name: _____

ID #: _____

Group No: _____

Subscriber's
Name: _____

Patient's Relationship
to Subscriber: _____

Subscriber's
Social Security No: _____-_____-_____

Subscriber's
Date of Birth: _____/_____/_____

Secondary:

Insurance
Company Name: _____

ID #: _____

Group No: _____

Subscriber's
Name: _____

Patient's Relationship
to Subscriber: _____

Subscriber's
Social Security No: _____-_____-_____

Subscriber's
Date of Birth: _____/_____/_____

Third:

Insurance
Company Name: _____

ID #: _____

Group No: _____

Subscriber's
Name: _____

Patient's Relationship
to Subscriber: _____

Subscriber's
Social Security No: _____-_____-_____

Subscriber's
Date of Birth: _____/_____/_____

Worker's Compensation:

Claim No: _____

Date of Injury: _____/_____/_____

Employer
at time of injury: _____

Address: _____

City/State/Zip: _____

Telephone No: (_____) _____ - _____

Contact Person: _____

MCO: _____

I authorize the release of any medical information by Ophthalmic Surgeons & Consultants of Ohio, Inc. for any insurance claims submission and at the doctor's discretion, assign the insurance payment to them for these services. I understand that I am financially responsible for the charges that are not covered.

Patient (or responsible party) Signature: X _____

Date: _____/_____/_____