Wexner Medical Center

William H. Havener Eye Institute
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Thank you for choosing the William H. Havener Eye Institute:

Please complete the enclosed forms and bring them with you to your first visit at our office. Enclosed please find directions and a map designed to help find your way to our office. Please note that co-payments and self pay balances are expected at the time of service. We accept cash, check, Visa and Mastercard.

Our Physicians are specialty physicians; please plan to spend 2-3 hours in our office. The physicians spend as much time as needed with each patient and emergency patients are common in our practice. As a result, you may experience a wait time. We will try to keep you apprised of any delays. We apologize in advance for any inconvenience to you this maybe. If you are a diabetic or use oxygen, please prepare for the potentially long wait. Your understanding is greatly appreciated.

Both of your eyes may be dilated for this examination. You may want to bring sunglasses and make arrangements to have someone drive you home from your appointment.

Please arrive for your appointment 15 minutes early in order to complete the registration process. **Be sure to have your Photo ID (drivers license) and insurance card(s) available at registration** so that we may have a copy for your record.

Remember that your insurance policy is a contract between you and your insurance carrier. It is your responsibility to know the terms of your policy; for example the innetwork providers, your co-pay and the referral process. Please make sure you obtain any referrals that may be necessary to fulfill the requirements of your policy.

Thank you for your cooperation. We look forward to seeing you!

ATTENTION PATIENTS!

If you have any of the insurances listed below, you must have the required paperwork at the time of service. If you do not have the appropriate authorization, our office may reschedule your appointment to allow you time to meet the obligations required by your insurance policy.

BWC (workers comp): You must bring a copy of a C9 (BWC form that indicates a request from another physician for us to see you) with you and/or the appropriate authorization from your managing physician. The C9 should also include authorization for any diagnostic testing or procedures that may be necessary.

TRINITY BGS, MEDICARE COMPLETED, ANTHEM SENIOR ADVANTAGE OR MEDIGOLD: You must have written approval from your insurance company to be seen. This approval is often referred to as an out-of-network referral or authorization. PLEASE NOTE: We also do not participate with any Medicare Advantage HMO plans.

HMO INSURANCES: You must have a referral from your Primary Care Physician in order for your visit to us to be covered by your insurance. Without the authorization, you will be required to pay for your visit in full at the time service or reschedule in order to allow time for you to obtain the appropriate authorization.

We are sorry for ANY inconvenience but your insurance company requires you to obtain this authorization in order to cover your visit to our office. The referring doctor can usually assist you, but it is ultimately your responsibility to make sure the process is completed.

If all the pieces are not in place, the charges associated with your visit to our office will NOT be paid your insurance company and WILL be your responsibility. Payment will be expected at the time of service as you check in to see us. If additional testing or procedures are required or recommended during your visit, you may want to discuss these with your physician. Based on the recommendations of your physician, a return appointment could be made to complete the necessary testing or procedures and to allow for you to obtain the appropriate authorizations. If the testing and/or procedures are performed at your initial visit, without contacting your insurance company, the charges will not be covered and you WILL be responsible for payment.

In sharing this information with you, we just want to make sure that you are well informed about how we expect your insurance company will handle your charges. The best way to make sure your charges will be covered is to contact your insurance company and obtain the appropriate authorization for your services with us.

Please let us know if we can answer any questions for you or help you with your authorizations.

Last Name: _____First: _____Age:_____ Sex: _____
Date:_____ Referred By:_____Occupation:_____

PATIENT HISTORY QUESTIONNAIRE

All information is strictly confidential and will be released only with written permission.

Current Medications: (Please list any medications including eye drops/ supplements/vitamins that you take.)
☐ None

Name of Medications **Eye Drops/Supplement/Vitamin**	**Dose (How much per day)**	**Name of Doctor Prescribing**

Drug Allergies with reactions:

_____
_____
_____
_____
_____

Social History:

Tobacco ☐ No ☐ Yes (including smokeless tobacco)
How many per day:_____ How long: _____
Have you used tobacco in the past? ☐ No ☐ Yes Approx. date started _____ Date stopped:_____
Alcohol ☐ No ☐ Yes
Number per week: _____ Wine _____Beer _____ Hard Liquor _____
Recreational Drugs ☐ No ☐Yes
Ever used intravenous drugs ☐ No ☐ Yes Date last used:_____
Marital Status: Married _____ Divorced _____ Single _____ Widowed _____ Student _____
Children: ☐ No ☐ Yes
Number _____
Hobbies/ Special Interests: _____

Reason for Visit: (Please explain the problems that bring you to our office today.)

_____
_____
_____
_____
_____

Surgical History:

Eye Surgeries/Laser Treatments ☐ None

Type of Operation: Date: Complications:

_____
_____
_____
_____
_____
_____

All Other Surgeries ☐ None

Type of Operation: Date: Complications:

_____
_____
_____
_____
_____
_____

Lab Testing/Studies:

Date Location Phone# (*if known*)

Blood Work:_____

X-Ray:_____

CAT Scan: _____

MRI: _____

Other:_____

Physician(s): Please give the name, address and phone numbers of any doctors you are currently seeing. If more space is needed, please use back of questionnaire.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History: (Mark any of the conditions that you currently have or have a history of and in the space provided please describe and indicate how long you have had this problem)

☐ **None**

Diabetes: ☐ **Y** ☐ **N** (☐ insulin / ☐ no insulin) Year Diagnosed _____ Last A1C _____

Allergies:	☐ **Y** ☐ **N** _____	**Osteoporosis:**	☐ **Y** ☐ **N** _____
Alzheimer's/Dementia:	☐ **Y** ☐ **N** _____	**Night Sweats:**	☐ **Y** ☐ **N** _____
Anemia/Bleeding Problems:	☐ **Y** ☐ **N** _____	**Heart Problems/CVD :**	☐ **Y** ☐ **N** _____
Arthritis (Osteo, Rheumatoid):	☐ **Y** ☐ **N** _____	**Hepatitis A, B, C:**	☐ **Y** ☐ **N** _____
Asthma/ Bronchitis:	☐ **Y** ☐ **N** _____	**High Blood Pressure:**	☐ **Y** ☐ **N** _____
Blindness:	☐ **Y** ☐ **N** _____	**High Cholesterol:**	☐ **Y** ☐ **N** _____
Blood Transfusion:	☐ **Y** ☐ **N** _____	**HIV /AIDS :**	☐ **Y** ☐ **N** _____
Cancer:	☐ **Y** ☐ **N** _____	**Lupus:**	☐ **Y** ☐ **N** _____
Depression:	☐ **Y** ☐ **N** _____	**Migraine:**	☐ **Y** ☐ **N** _____
Emphysema/ COPD:	☐ **Y** ☐ **N** _____	**Sickle Cell Anemia:**	☐ **Y** ☐ **N** _____
Epilepsy/Seizures:	☐ **Y** ☐ **N** _____	**Stroke :**	☐ **Y** ☐ **N** _____
Glaucoma:	☐ **Y** ☐ **N** _____	**Thyroid Disease:**	☐ **Y** ☐ **N** _____
Kidney/Urinary Problems:	☐ **Y** ☐ **N** _____	**Tuberculosis(TB):**	☐ **Y** ☐ **N** _____
Ulcer/Stomach Problems:	☐ **Y** ☐ **N** _____	**Other:**	☐ **Y** ☐ **N** _____

Family Medical History: (In the space provided please indicate relationship. For example "maternal grandmother", "paternal grandfather" or "brother" ect.)

Anemia:	☐ **Y** ☐ **N** _____	**Heart Problems/Disease:**	☐ **Y** ☐ **N** _____
Arthritis:	☐ **Y** ☐ **N** _____	**Hepatitis:**	☐ **Y** ☐ **N** _____
Bleeding Problems:	☐ **Y** ☐ **N** _____	**High Blood Pressure:**	☐ **Y** ☐ **N** _____
Blindness:	☐ **Y** ☐ **N** _____	**Macular Degeneration:**	☐ **Y** ☐ **N** _____
Cancer:	☐ **Y** ☐ **N** _____	**Migraine/ Headaches:**	☐ **Y** ☐ **N** _____
Cataract:	☐ **Y** ☐ **N** _____	**Retinal Detachment:**	☐ **Y** ☐ **N** _____
Corneal Problems:	☐ **Y** ☐ **N** _____	**Sickle Cell:**	☐ **Y** ☐ **N** _____
Diabetes:	☐ **Y** ☐ **N** _____	**Stroke:**	☐ **Y** ☐ **N** _____
Emphysema:	☐ **Y** ☐ **N** _____	**Thyroid Disease:**	☐ **Y** ☐ **N** _____
Epilepsy/Seizures:	☐ **Y** ☐ **N** _____	**Tuberculosis (TB):**	☐ **Y** ☐ **N** _____
Glaucoma:	☐ **Y** ☐ **N** _____	**Other :**	☐ **Y** ☐ **N** _____

REVIEW OF SYSTEMS
CHECK those that apply or CHECK - NONE

Health in general: ☐ Chills, ☐ Fatigue, ☐ Fever, ☐ Weight Gain, ☐ Weight Loss,
☐ Other _____ ☐ **NONE**

Skin: ☐ Excessive dryness, ☐ itching, ☐ skin lesion, ☐ rash (*eczema, psoriasis, rosacea*)
☐ Other _____ ☐ **NONE**

Ears, Nose, Mouth, Throat: ☐ Sinus pain, ☐ ear discharge, ☐ ear pain, ☐ hearing loss, ☐ tinnitus (*ringing/buzzing/swoosh*), ☐ nasal congestion, ☐ nosebleeds, ☐ rhino rhea (*runny nose*), ☐ hoarseness, ☐ sore throat, ☐ Other _____ ☐ **NONE**

Cardiovascular: ☐ Chest pain, ☐ claudication(*leg pain/cramping)*, ☐ dyspnea on exertion(*shortness of breath with effort*), ☐ leg swelling, ☐ orthopnea(*shortness of breath while laying down*), ☐ palpitations, ☐ Other _____ ☐ **NONE**

Respiratory: ☐ Cough, ☐ hemoptysis (*coughing up blood*), ☐ shortness of breath, ☐ sputum, ☐ production, ☐ wheezing, ☐ sleep apnea (cpap Y/N), ☐ Other _____ ☐ **NONE**

Gastrointestinal: ☐ Abdominal pain, ☐ belching, ☐ blood in stool, ☐ constipation, ☐ diarrhea, ☐ heartburn, ☐ hemorrhoids, ☐ nausea, ☐ trouble swallowing, ☐ vomiting,
☐ Other _____ ☐ **NONE**

Genitourinary: ☐ Irregular menses, ☐ bladder incontinence, ☐ polyuria(*frequent urination*), ☐ dysuria (*painful urination*), ☐ Other _____ ☐ **NONE**

Muscle, Joint and Bone: ☐ Back pain, ☐ falls joint pain, ☐ myalgias (*muscle pain*), ☐ neck pain, ☐ Other _____ ☐ **NONE**

Neurological: ☐ Dizziness, ☐ focal weakness, ☐ headache, ☐ loss of consciousness, ☐ seizures, ☐ speech change, ☐ tingling, ☐ tremor, ☐ Other _____ ☐ **NONE**

Psychiatric: ☐ Depression, ☐ hallucinations, ☐ insomnia, ☐ memory loss, ☐ nervous/anxious, ☐ Other _____ ☐ **NONE**

Allergic/ Immunology: ☐ Environmental allergies, ☐ Other _____ ☐ **NONE**

Blood and Lymph: ☐ Easy bruise/ bleed, ☐ lymph node swelling,
☐ Other _____ ☐ **NONE**

Glands and Endocrine: ☐ Hot flashes, ☐ polydipsia, (frequent thirst), ☐ sweating,
☐ Other _____ ☐ **NONE**