Ohio Vision, LLC

John J. Wilding, D.O. ● William E. Schemmel, O.D.

Patient Registration

Today's Date: ______________

Name ____ Social Security # ________________
Last First Mi

Street ___________________________________ City ________________ State ________ Zip ____________

Birthdate ______/______/________ Age ______ Sex: M F Married ____ Divorced_____
Single _____ Widowed ____

Home Phone ____________________ Work Phone __________________ Cell Phone ___________________

E-Mail Address: _________________________

Employer ____
Name Address

Spouse ____________________________ Social Security # __________________ Birthdate _____________

Spouse's Employer ____
Name Address

Emergency Contact ___________________________________ Emergency Phone ____________________

Financial: Person Responsible ____
Last First Mi

Street ___________________________________ City ________________ State ________ Zip ____________

Relationship to Patient: Self _____ Spouse _____ Parent _____ Other ______________________

____
Primary Insurance Policy Holder Policy ID SS# Insured DOB

____
Secondary Insurance Policy Holder Policy ID SS# Insured DOB

All co-pays are due at the time of service __________________________
Your co-pay amount

Who may we thank for telling you about our practice? ____

____
Family Doctor Address Phone

____
Family Optometrist Address Phone

FINANCIAL AND MEDICAL POLICY (APPLICABLE TO ALL PATIENTS)

Your health insurance policy is an agreement between you and your insurance carrier for reimbursement of fees paid to the physician, & is usually not designed to pay the entire fee. Regardless of your medical coverage, we rely on you for settling your account. You are ultimately responsible for all office & surgery fees relating to your care. If we have a problem collecting from your insurance company, we will ask you to become involved. Whatever service your insurance does not cover, you will be responsible for payment.

I authorize the release of any medical information necessary to process this claim, and I authorize the release of payment for medical benefits to my physician.

I understand & agree with the above statement:____
Signature of Patient (Required) Date

PATIENT CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: ____

Relationship to Patient (if other than patient):_______________________________

Date:______________________________

PLEASE CHECK □ if, you give permission to Ohio Vision to discuss your medical care with: _________________________ (name and relationship to patient)

PLEASE CHECK □ if, you give permission to Ohio Vision to leave a message on your home answering machine regarding your care.

In front of _______________________________________
Printed name – Practice representative

PATIENT PERSONAL HEALTH HISTORY

(complete form in ink only)

Today's Date:________________________

Name:____ Sex: M F Date of Birth:_______________________ Age:_______

REVIEW OF SYSTEMS:

Do YOU presently have any problems in the following areas? If Yes, Please Explain

Area	Yes	No	If Yes, Please Explain
Allergies & Immunologic	❑ Yes	❑ No	______________________
Bones, joints, and muscles	❑ Yes	❑ No	______________________
Cardiovascular (heart / blood vessel)	❑ Yes	❑ No	______________________
Ear, Nose, Throat	❑ Yes	❑ No	______________________
Gastrointestinal (stomach / intestines)	❑ Yes	❑ No	______________________
Genitourinary	❑ Yes	❑ No	______________________
Headaches	❑ Yes	❑ No	______________________
Blood Disease	❑ Yes	❑ No	______________________
Skin Disease	❑ Yes	❑ No	______________________
Lymphatic (lymph nodes / swelling)	❑ Yes	❑ No	______________________
Neck / Spine	❑ Yes	❑ No	______________________
Neurological System	❑ Yes	❑ No	______________________
Psychiatric (depression, anxiety, breakdown)	❑ Yes	❑ No	______________________
Respiratory (lungs and breathing)	❑ Yes	❑ No	______________________

SPECIFIC:

____ Arthritis
____ Asthma
____ Bronchitis
____ Bleeding Tendencies
____ Cancer / Tumors
____ Chest Pain
____ Chicken Pox
____ Diabetes
____ Emphysema / COPD
____ Gout

________ Hearing Impairment
________ Heart Disease
________ Hemorrhoids
________ Hepatitis / Liver Disease
________ Hernia
________ High Blood Pressure
________ Kidney Stones
________ Nervous Breakdown / Depression / Anxiety
________ Neuritis

____ Rheumatic Fever
____ Stroke
____ Thyroid Disease
____ Tuberculosis
____ Ulcers (Stomach)
____ Venereal Disease
____ Other ____________________

ARE YOU ALLERGIC TO ANY MEDICATIONS

( ) Yes ( ) No ( ) Don't Know If Yes, Which Medicine(s)?

____

____

SOCIAL HISTORY:

Do you smoke? Yes No If yes, how much? ______________________________

Do you drink alcohol? Yes No If yes, how much? ______________________________

Do you use illegal drugs? Yes No If yes, how much? ______________________________

Has anyone in your immediate **BLOOD-RELATED FAMILY** ever had:

Arthritis	_____ Yes	_____ No	High Blood Pressure	_____ Yes	_____ No
Blindness	_____ Yes	_____ No	Kidney Disease	_____ Yes	_____ No
Cancer	_____ Yes	_____ No	Macular Degeneration	_____ Yes	_____ No
Cataract	_____ Yes	_____ No	Retinal Detachment	_____ Yes	_____ No
Diabetes	_____ Yes	_____ No	Stroke	_____ Yes	_____ No
Glaucoma	_____ Yes	_____ No	Thyroid Disease	_____ Yes	_____ No
Heart Attacks	_____ Yes	_____ No			

CURRENT EYE DROPS:

Name	Dose (Mg)	Times / Day

OTHER MEDICATIONS:

Name	Dose (Mg)	Times / Day

PREVIOUS EYE SURGERIES:

Type	Place	Date

PREVIOUS GENERAL SUGERIES:

Name	Place	Date

Please circle the answer the best fits your situation.

1. Does your vision with glasses make it a problem for you to: (Circle one number in each row)

	Never	Sometimes	Frequently
a. Read traffic signs	0	1	2
b. Drive during the daytime	0	1	2
c. Drive at night	0	1	2
d. See steps	0	1	2
e. Read labels on medicine bottles	0	1	2
f. Read a magazine or newspaper	0	1	2
g. Watch television	0	1	2
h. Do household chores	0	1	2
i. Identify colors	0	1	2
j. Do things you have done in the past	0	1	2

2. How much are you hindered, limited or disabled by glare (dazzling light) in each of the following activities? (Circle one number in each row)

	Never	Sometimes	Frequently
a. Your normal daily activities	0	1	2
b. Driving towards the sun or oncoming headlights	0	1	2
c. Walking outside on a sunny day	0	1	2

3. Have you noticed or been told by others that your color perception is altered? (Circle one)
   YES NO
4. Did you need assistance filling out this form because of your vision? (Circle one)
   YES NO

Patient's Signature ____