SEEMA J. ICE, M.D. / CARL K. SHIN, M.D.

OPHTHALMOLOGY & OPHTHALMIC SURGERY

2141 MENTOR AVE
PAINESVILLE, OHIO 44077
(440)354-6900

PATIENT INFORMATION FORM

Welcome to our office. Please complete this form and return it to the receptionist so your chart can be prepare

DATE _____

PATIENT'S NAME		SOCIAL SECURITY #		SEX M F	AGE / BIR
ADDRESS	STREET	CITY	STATE	ZIP	PHONE #
OCCUPATION		EMPLOYER		EMPLOYER ADDRESS	
NAME OF SPOUSE		EMPLOYER			
IF UNDER 18 YEARS OF AGE OR A STUDENT	NAME OF FATHER		EMPLOYER		
	NAME OF MOTHER		EMPLOYER		

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? ☐ YES ☐ NO | MAY WE LEAVE A MESSAGE WITH A FAMILY MEMBER? ☐

NAME OF INSURANCE & POLICY NUMBER _____

AUTHORIZATION FOR MEDICARE OR OTHER INSURANCE CARRIER PAYMENTS TO CARL K. SHIN, M.D., INC.

I AUTHORIZE THE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS AND RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES. I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANC COMPANY AND DIRECT PAYMENT TO MY DOCTOR

SIGNATURE _____ DATE / /

PAYMENT OF FEES IS THE RESPONSIBILITY OF PATIENT USUALLY DUE AT THE TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE

MEDICAL INFORMATION

WHO REFERRED YOU TO OUR OFFICE?		FAMILY DOCTOR'S NAME	
ARE YOU HERE BECAUSE OF AN EYE INJURY? IF SO, DID IT OCCUR AT WORK?	☐ YES ☐ NO ☐ YES ☐ NO	DATE OF ONSET / /	ARE YOU HERE FOR A REGULAR CHECK-UP? ☐ YES
IF YOU ARE HAVING PROBLEMS WITH YOUR EYE(S) PLEASE DESCRIBE:			
DO YOU WEAR GLASSES? DO YOU WEAR CONTACT LENSES?	☐ YES ☐ NO ☐ YES ☐ NO	DATE OF YOUR LAST EYE EXAM? / /	DO YOU USE EYE DROPS ROUTINELY? ☐ YES
MEDICATIONS PLEASE LIST NAMES:			
ARE YOU ALLERGIC TO ANY MEDICINE? ☐ YES ☐ NO IF SO, PLEASE LIST			DO YOU SMOKE? ☐ YES
DO YOU HAVE (OR DID YOU EVER HAVE): (CHECK ALL THAT APPLY)			DID ANYONE IN YOUR FAMILY H

DO YOU HAVE (OR DID YOU EVER HAVE): (CHECK ALL THAT APPLY)

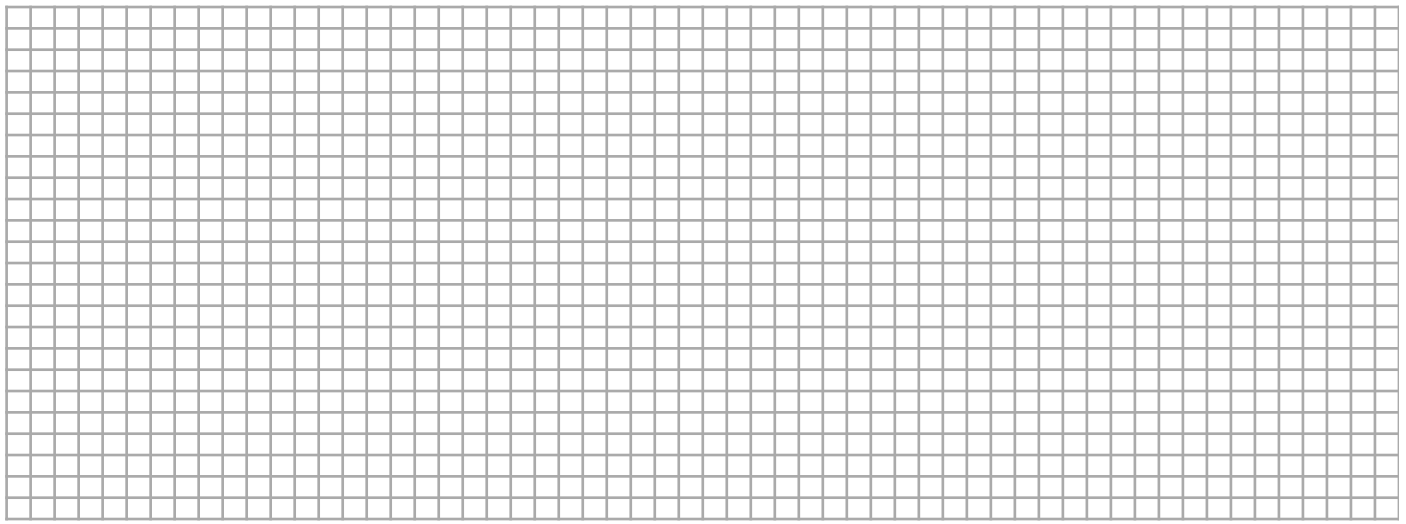
YES	NO		YES	NO	
☐	☐	DIABETES	☐	☐	CATARACT
☐	☐	ARTHRITIS	☐	☐	GLAUCOMA
☐	☐	THYROID DISEASE	☐	☐	MACULAR DEGENERATION
☐	☐	SKIN DISEASE	☐	☐	LAZY EYE
☐	☐	HEART ATTACK	☐	☐	CROSSED EYE
☐	☐	AIDS/HIV	☐	☐	COLOR BLINDNESS
☐	☐	STROKE	☐	☐	EYE SURGERY
☐	☐	HEPATITIS	☐	☐	EYE INJURY
☐	☐	HIGH BLOOD PRESSURE			

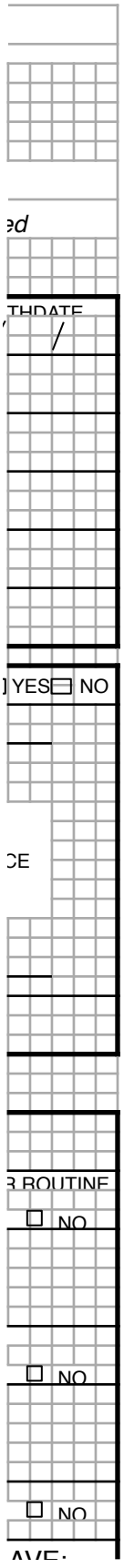
OTHER ILLNESSES?_____

DID ANYONE IN YOUR FAMILY H

YES	NO	
☐	☐	CATARACT
☐	☐	GLAUCOMA
☐	☐	MACULAR DEGENERATION
☐	☐	LAZY EYE
☐	☐	CROSSED EYE
☐	☐	COLOR BLINDNESS
☐	☐	EYE SURGERY
☐	☐	DIABETES
☐	☐	HIGH BLOOD PRESSURE

OTHER ILLNESSES?_____

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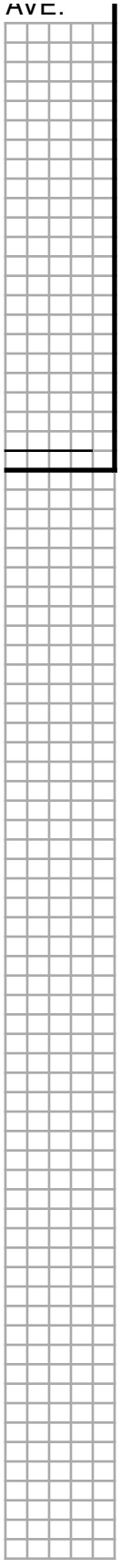
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