COLUMBUS LASER and CATARACT CENTER
PATIENT INFORMATION FORM

Please List your current Eye Doctor and Family Doctor:

Optometrist:____ Phone: ( )_____________________

Family Dr.:____ Phone: ( )_____________________

Last Name____ First Name_________________________________ M.I.______________

Street Address____ City_______________________ State______ Zip____________

Birthdate_________/_________/_________ Age________ S.S. #__________-_______-__________ Sex: Male Female

Please provide e-mail and cell phone as alternatives for reaching you for scheduling changes and emergencies.

Email ____ Cell Phone ( ) _________-_______________

Home Phone ( ) _________-_______________ Work Phone ( ) _________-_______________

Employer____ Occupation____

Spouse's Name: Last_______________________________________ First_________________________________ M.I._____________

Emergency Contact____ Relationship_______________________________________

Telephone # ( )__________________________

INSURANCE INFORMATION (Please Bring Your Insurance Cards)

Do you belong to VSP (Vision Service Plan) YES NO Other vision plan? ______________________________.

Does your Primary Insurance Company cover laser eye surgery? YES NO If yes bring cards and fill out below:

Name of Insured:_______________________________________ **SSN:** ______-_____-________ **DOB:** _____/_____/________
(if other than self)

Primary Insurance Company:____ (Copy of Insurance card for our files)

Secondary Insurance Company:_______________________________________ (Copy of Insurance card for our files)

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this notice. We must follow the privacy practices as described in CLCC notice of privacy practices. This notice takes effect April 14, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our office. All information about how your medical information may be used is described in the notice. By signing this form, you have acknowledged our privacy practices and that a copy of the Columbus Laser and Cataract Center Notice of Privacy Practices has been made available to you.

Columbus Laser and Cataract center is required by law to maintain the privacy of our patient's health information. Unless you have signed a form authorizing the use or disclosure, we will not use or disclose your health information for any purpose other than CLCC's role in treatment, payment or for health care operations. With your written approval, we may disclose your health information to others, including designated family friends, or others who are involved in your health care or in payment for your health care.

Signature____Date____________________________________