Welcome to Drs. Chandler & Timmerman's Office

Name (First)_____(MI)_____(Last)_____

Address_____

City_____ State_____ Zip_____

Home Phone_____

Cell Phone_____

E-mail address_____

Birthdate_____ Age_____ Gender M / F

Social Security Number_____

Occupation_____

Employer _____

Business Phone _____

Marital Status: single/ married/ divorced/ widow

Spouse or Parents_____
(circle)

Emergency Name & Number_____

PLEASE CIRCLE ONE OF EACH:

- Preferred language: English / Spanish
- Race: American Indian / Arabic/ Asian / Black or African American / Hispanic / Indian / Native Hawaiian or Other Pacific Islander / White
- Ethnicity: Hispanic or Latino / Native Hawaiian or Other Pacific Islander / Not Hispanic or Latino
- Communication Preference: Email / Postal / Telephone

Personal Physician _____

Physician Phone_____

Last Eye Doctor_____Last Eye Exam_____

Insurance & Billing Information

Vision Insurance _____

Policy Holder's Relation to patient (circle) self, spouse, parent

Name (First)_____(MI)_____(Last)_____

Address_____

City_____ State_____ Zip_____

Home Phone_____

Employer_____

Date of Birth_____

Social Security Number_____

Medical Insurance _____

Member ID: _____ Group #_____

Policy Holder's Relation to patient (circle) self, spouse, parent

Name (First)_____(MI)_____(Last)_____

Address_____

City_____ State_____ Zip_____

Home Phone_____

Employer_____

Date of Birth_____

Social Security Number_____

How did you hear about this office?_____

Payment for co-pay or any contact lens charges are due at time of service.

** Please note that most insurances do NOT cover the Contact Lens re-evaluation or any contact lens follow-up. (VSP & EyeMed may) **

Assignment of Benefits

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:
Centerville Family Eye Care 125 E. Franklin St. Centerville, OH 45459
Or if my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows: c/o **Centerville Family Eye Care 125 E. Franklin St. Centerville, OH 45459**
for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original.
I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ _____
Signature of Policyholder (or Claimant) Date

CENTERVILLE FAMILY EYE CARE
Jeff L. Chandler, O.D.
Lisa M. Timmerman, O.D., M.S.
125 E. Franklin Street
Centerville, OH 45459
phone: 937.435.8605
fax: 937.684.4947

Name: _____

DOB: _____

Medical History

What is the reason for your visit to us today? _____

Are you having any of the following or have you recently?

- ❑ Allergies- Ocular
- ❑ Blurred Vision – Night
- ❑ Blurred Vision - Distance
- ❑ Blurred Vision - Computer distance or Near
- ❑ Blurred Vision – overall feeling of blur
- ❑ Burning eyes
- ❑ Contact Lens discomfort
- ❑ Discharge
- ❑ Discomfort
- ❑ Double Vision
- ❑ Dry Eye
- ❑ Eye Strain or fatigue
- ❑ Eye Trauma
- ❑ Flashes of light
- ❑ Floaters
- ❑ Foreign Body Sensation
- ❑ Glare
- ❑ Halos
- ❑ Headache
- ❑ Itchy Eyes
- ❑ Lid Twitching
- ❑ Light sensitivity
- ❑ Loss of side vision
- ❑ Pain
- ❑ Redness
- ❑ Sandy / gritty feeling
- ❑ Watery eyes

Are you returning for any of the following?

- ❑ Cataract Evaluation
- ❑ Diabetes
- ❑ Glaucoma Evaluation
- ❑ Macular Degeneration
- ❑ Post-op Cataract
- ❑ Post-op LASIK

- ❑ Doctor recommended visit
- ❑ Other

Patient's Ocular History

- ❑ Amblyopia
- ❑ ARMD (Macular Degeneration)
- ❑ Cataract
- ❑ Glaucoma
- ❑ Keratoconus
- ❑ Trauma
- ❑ other
- ❑ none of above

Please list any ocular surgeries.

_____
_____
_____
_____

Systemic Family History

(please list family relation)

- ❑ Diabetes
- ❑ Hypertension
- ❑ Thyroid disease
- ❑ Heart disease
- ❑ Marfan's Syndrome
- ❑ unknown/ adopted
- ❑ other
- ❑ none of the above

Ocular Family History

- ❑ Blindness
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Retinal tear or Detachment
- ❑ unknown/ adopted
- ❑ none of the above

Social/ Occupational History

- ❑ Tobacco use
  - ❑ Smoker – current everyday
  - ❑ Smoker – current someday
  - ❑ Smokeless tobacco user
- ❑ Alcohol use
- ❑ Sexually Transmitted Disease
- ❑ Blood Transfusion
- ❑ Narcotic use
- ❑ none of above

Allergy

- ❑ environmental allergy
- ❑ drug allergy

Please list all allergies to medications

_____
_____
_____
_____

- ❑ none of above

PLEASE LIST NAMES OF MEDICATIONS TAKEN

Ocular Medications (List names)

_____

_____

Systemic Medications (List name & dosage)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

- ❑ Not taking any medications

Review of Systems (ROS) Please check those that apply.

Allergy

❑ allergies- listed on previous sheet
❑ no allergies

Cardiovascular

❑ Angina
❑ Arrhythmia
❑ Atheriosclerosis
❑ Cardiovascular Disease
❑ Congestive Heart Disease
❑ Elevated cholesterol
❑ Endocarditis
❑ Heart Murmur
❑ Heart Palpitations
❑ Hypertension (High Blood Pressure)
❑ Mitral Valve Prolapse
❑ Myocardial Infarction (Heart Attack)
❑ Stroke
❑ other _____
❑ none of above

Constitutional

❑ Dizziness
❑ Fainting
❑ Fatigue
❑ Growth (excess)
❑ Hunger (excess)
❑ Thirst (excess)
❑ Urination (excess)
❑ Weakness
❑ Weight Loss
❑ other_____
❑ none of above

Endocrine

❑ Crohn's Disease
❑ Diabetes
  ❑ Type 1
  ❑ Type 2
❑ Diabetes Suspect
❑ Gout
❑ Hypoglycemia
❑ Pituitary Disorder
❑ Renal Disease
❑ Thyroid Disorder
  ❑ Hyperthyroidism
  ❑ Hypothyroidism
  ❑ Hashimotos

❑ other_____
❑ none of above

Gastrointestinal

❑ Acid-Reflux Syndrome
❑ Alcoholism
❑ Anorexia
❑ Cancer
❑ Cirrhosis
❑ Colitis
❑ Diverticulosis
❑ Dyspepsia
❑ Gall Bladder removed
❑ Gall Stones
❑ Gardner's Syndrome
❑ Gastritis
❑ Gastroenteritis
❑ Gastroesophageal Reflex
❑ Gastrointestinal Disorder
❑ Hepatitis
❑ Hepatic Disease
❑ Hiatus Hernea
❑ Inflammatory Bowel
❑ Intestinal Obstruction
❑ Jaundice
❑ Pancreatitis
❑ Ulcer
❑ Wipple's Disease
❑ other_____
❑ none of above

Genitourinary

❑ Currently Pregnant
❑ Bladder infections
❑ Impotence
❑ Kidney Stones
❑ Menopause
❑ Ovarian Cyst
❑ Pelvic Inflammatory Disease
❑ Prostate Disorder
❑ Prostate Cancer
❑ STD
❑ Syphilis
❑ Uterine Cancer
❑ other_____
❑ none of above

Head (Ears, Nose, Mouth, Throat)

❑ Chronic Cough
❑ Dental Disorder
❑ Dry mouth
❑ Ear infection
❑ Encephalitis
❑ Gingivitis
❑ Hearing Loss (full)
❑ Hearing Loss (impaired)
❑ Meniere's Syndrom
❑ Sinusitis
❑ other_____
❑ none of above

Hematologic/ Lymphatic

❑ Anemia
❑ Breast Cancer
❑ Cavernous Sinus
❑ Thrombosis
❑ Coagulation Disorder
❑ Hematologic Disorder
❑ Hodgkin's Disease
❑ Leukemia
❑ Lymphatic Cancer
❑ Pernicious Anemia
❑ Polycythemia
❑ Temporal Arteritis
❑ Thalassemia
❑ Varicose Veins
❑ other_____
❑ none of above

Immunologic

❑ Acquired Immunodeficiency
❑ AIDS
❑ Bacterial infection
❑ Chicken Pox (in past)
❑ Cyclomegalovirus
❑ Diphtheria
❑ Herpes Simplex
❑ Herpes Zoster (Shingles)
❑ Histoplasmosis
❑ HIV Positive
❑ Lyme Disease
❑ Measles (in past)
❑ Mononucleosis
❑ Molluscum Contagiosum
❑ Mumps (in past)
❑ Newcastle Disease
❑ Reye's Disease
❑ Rheumatic Fever
❑ Rubella
❑ Sarcoidosis
❑ Sjogren's Syndrome
❑ Syphilis
❑ Tetanus
❑ Tuberculosis
❑ other_____
❑ none of above

Integumentary (Skin)

❑ Acne
❑ Acne Rosacia
❑ Albinism
❑ Atopic Dermatitis
❑ Cicatrical Pemphigoid
❑ Contact Dermatitis
❑ Dermatitis
❑ Dry Skin
❑ Erythema Multiforme
❑ Erythema Nodosum
❑ Hypertrichosis
❑ Impetigo
❑ Lupus
❑ Ocular Rosacia
❑ Pemphigus
❑ Polyarteritis Nodosa
❑ Psoriasis
❑ Pruritis
❑ Raynaud's Disease
❑ Sarcoid Lesion
❑ Scleroderma
❑ Skin Cancer
❑ Urticara
❑ Vitiligo
❑ Warts
❑ Xeroderma
❑ other_____
❑ none of above

Muskuloskeletal

❑ Ankylosing Spondylitis
❑ Arthritis
❑ Arthritis – Rheumatoid
❑ Down's Syndrome
❑ Marfan's Syndrome
❑ Muscular Dystrophy
❑ Myasthenia Gravis
❑ Osteoporosis
❑ Paget's Disease
❑ Polymyalgia Rheumatica
❑ Sacroilitis
❑ Scoliosis
❑ Skeletal Disorder
❑ other_____
❑ none of above

Neurological

❑ Bell's Palsy
❑ Brain Damage
❑ Brain Tumor
❑ Cerebral Palsy
❑ Dyslexia
❑ Encephalitis
❑ Epilepsy
❑ Headache
❑ Headache (Migraine)
❑ Horner's Syndrome
❑ Muscular Dystrophy
❑ Multiple Sclerosis
❑ Mysthania Gravis
❑ Neuralgia
❑ Neurofibromatosis
❑ Nystagmus
❑ Olfactory Disorder
❑ Parkinson's Disease
❑ Seizure Disorder
❑ Spinal Cord Injury
❑ Sturge-Weber Syndrome
❑ Trigeminal Neuralgia
❑ Tuberous Sclerosis
❑ Vertigo
❑ von Hippel-Lindau Disease
❑ other_____
❑ none of above

Psychiatric

❑ Attention Disorder (ADD)
❑ Alzheimer's Disease
❑ Anorexia
❑ Anxiety Disorder
❑ Autism
❑ Bi-Polar Disorder
❑ Brain Damage (Trauma)
❑ Bulimia
❑ Delusions
❑ Dementia
❑ Depression
❑ Drug Dependency
❑ Insomnia
❑ Learning Disability
❑ Memory Loss (Short Term)
❑ Mentally Challenged
❑ Mentally Retardation
❑ Personality Disorder
❑ Psychiatric Disorder
❑ Schizophrenia
❑ Suicidal Ideation
❑ other_____
❑ none of above

Respiratory

❑ Asthma
❑ Asthma, exercise induced
❑ Bronchitis
❑ Cancer: Lung
❑ COPD
❑ Cystic Fibrosis
❑ Emphysema
❑ Lung Disease
❑ Pneumonia
❑ Pleurisy
❑ Pulmonary Insufficiency
❑ Respiratory Dysfunction
❑ Smoker (Heavy)
❑ Tuberculosis
❑ other _____
❑ none of above

List any other medical conditions not listed above:

_____

_____

_____

_____

_____

_____

_____

Signed: Date:

CENTERVILLE FAMILY EYE CARE
Jeff L. Chandler, O.D.
Lisa M. Timmerman, O.D., M.S.
125 E. Franklin Street
Centerville, OH 45459
phone: 937.435.8605
fax: 937.684.4947

Permission to Share Medical Information

I give Centerville Family Eye Care permission to share any of my medical information with:

_____

Name & Relation

_____

Name & Relation

_____ _____

Signed date

Centerville Family Eye Care Office Policies

___ It is my responsibility to know my insurance carrier and coverage. There is no guarantee that my insurance carrier will pay for my services. If my claim is denied, I understand that I am responsible for the balance.

___ We will gladly submit a claim for your primary insurance. We do not bill secondary insurance policies. We will provide you with a copy of your receipt when the balance is paid in full. You can submit this receipt for reimbursement from your secondary insurance.

___ We will file with the insurance company you have listed on your questionnaire, if you failed to list an insurance, we cannot go back and file with an insurance after you have checked out.

___ Payment for co-pays or any contact lens services are due at the time of service.

___ When ordering glasses or contacts, we require at least half down for the order to be placed. The remaining balance is due at the time of pick up.

___ Any outstanding balances over 30 days will have a 2% per month service charge.

_____ _____

Signed Date