Canton Ophthalmology Associates, Inc.

Jamie L. Zucker, M.D. · Barbara J. Barchiesi, M.D. · Jeffrey L. Congeni, M.D. · Marla Close, O.D.
2600 Tuscarawas St. W, Suite 200, Canton OH 44708-4693

PATIENT INFORMATION

To better serve you, we have converted to an electronic medical record (EMR) system. Due to regulations governing this type of system, there is pertinent data that we must obtain on every patient that is required to be included in their electronic medical record. Be assured that this information is protected by our HIPAA Privacy Practices (the same as a paper chart) and is further protected by the computer security protocols required for electronic health records.

Today's date: _______________ **PLEASE PRINT OR WRITE CLEARLY AND READABLY IN BLUE OR BLACK INK.**

FULL LEGAL NAME OF PATIENT:

First:___________________________ Middle initial: _____ Last:_____________________________

Street Address: ____

City: ___________________________________ State: __________ Zip code:

____

Phone #'s: (home - landline) _________________________ (Cell) _________________________

E-mail: ____

Date of birth**: _________________ SSN: _________________________ ☐ Male ☐ Female

If this patient is a minor or is still covered under their parent or guardian's insurance, you will need to complete the "Guarantor Information" section on the next page.

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Single

Patient's employment status:☐ Full time ☐ Part time ☐ Retired ☐ Disabled ☐ Not employed

Patient's employer: ____

Address/City/State/Zip: ____

Patient's work phone # _________________________ Occupation: _______________________________

If married: Spouse's name: ___________________________________ Spouse's phone #: _______________

Spouse's Social Security No. _________________________ Date of birth: ___________________

Spouse's employment status: ☐ Full time ☐ Part time ☐ Retired ☐ Disabled ☐ Not employed

Spouse's employer: ____

Address/City/State/Zip: ____

Spouse's work phone # _________________________ Occupation: _______________________________

Emergency contact: First & last name ____

Relationship to patient (e.g. sister, friend): _______________________ Phone #

____

Health Insurance Information: *Please present insurance card(s) to be copied.*
If card(s) not available, an additional Insurance Information form must be completed.

Does patient have routine vision care (non-medical) insurance coverage?

☐ No ☐ Yes (specify name of insurance, e.g. VSP, Eyemed, Spectera):

____

~PLEASE TURN OVER FOR ADDITIONAL INFORMATION NEEDED~

GUARANTOR [Guarantor = Insurance Policy Holder] INFORMATION

✶If patient is a minor or is still covered under parent/guardian's insurance, please complete this section:

Guarantor's relationship to patient: ☐Father ☐Mother ☐ Guardian ☐Other [specify] ________________________

Guarantor's name: ____

Guarantor's address: ____
(if different from patient's address)

Guarantor's phone #'s: (home landline) ____________________ (Cell) ____________________

Guarantor's Social Security no. ____________________ Date of birth: ____________________

Guarantor's employer: ______________________________ Work phone # __________________

Guarantor's employment status: ☐ Full time ☐ Part time ☐ Retired ☐ Unemployed

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***NOTE: If the guardian is NOT the guarantor** [see above], please complete this section.

Guardian (if **not** mother or father): Name: ____

Guardian's relationship to patient (e.g. grandparent, foster parent): ___________________________

Guardian's address: ____
(if different from patient's address)

Guardian's phone #'s (home landline) __________________ (Cell) ____________________

Guardian's Social Security no. ____________________ Date of birth: ____________________

Guardian's employer: ______________________________ Work phone # ____________________

Does patient currently have tuberculosis (TB)? ☐ No ☐ Yes➔ ☐ Active ☐ Inactive
Date diagnosed: ____________
On any TB medication? ☐ No ☐ Yes ➔ specify: ____

Patient referred to Canton Ophthalmology by: ____

Primary Care Physician (family physician) name:

____

PCP's phone # __________________________ Office location: ____________________________

Optometrist (O.D.): ______________________________________ Phone # __________________________

Does patient see any other physician specialists (e.g. endocrinologist for diabetes, cardiologist)? □ No □ Yes▶

1. Specialist name: ______________________________ Office location: ____________________________

Phone # ____________________ Specialty: _____________________________

2. Specialist name: ________________________________ Office location: _____________________________

   Phone # ____________________ Specialty: _____________________________

3. Specialist name: ________________________________ Office location: _____________________________

   Phone # ____________________ Specialty: _____________________________

Thank you!