Yoongie E. Min, O.D. ~ Marie E. Schiff, O.D.
2200 W. Henderson Road, Suite A ~ Columbus, OH 43220
(614) 273-2020 ~ FAX (614) 273-4335

Patient Name____ Sex M F

By what name do you prefer to be called_______________________________________

If patient is a minor, please print parent/guardian name_______________________________

Street Address____

City, State, Zip Code____

Phone Numbers: Home__________________ Work__________________ Cell__________________

Can we text you? ________ E-Mail Address_______________________________________

Date of Birth _____/_____/_____ Social Security Number_______________________________

Marital Status: S M D W Spouse's Name _______________________________

Employer ______________________________ Occupation______________________________

Please list immediate family members who are patients here_______________________________

How did you find our office? Referral Yellow Pages Insurance List Advertisement Internet

Whom may we thank for referring you to us?_______________________________________

DO YOU HAVE ANY **PERSONAL** HISTORY (**NOT FAMILY HISTORY**) OF THE FOLLOWING?

Cataracts	Y	N	Headaches	Y	N
Glaucoma	Y	N	Diabetes	Y	N
Lazy or Crossed Eye	Y	N	High Blood Pressure	Y	N
Eye Injury	Y	N	Heart Disease	Y	N
Eye Surgery	Y	N	Asthma	Y	N
Eye Pain	Y	N	High Cholesterol	Y	N
Depression/Anxiety	Y	N	Smoking	Y	N
Currently Pregnant	Y	N	Alcohol Use	Y	N

Current Medications____

Allergies(including medication allergies)_______________________________________

Current family physician, address & phone_______________________________________

Please describe any **family history** of eye or medical problems_______________________________

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Do you currently wear glasses?	Y	N
Do you currently wear contact lenses?	Y	N
Are you interested in contact lenses?	Y	N
Are you interested in laser vision correction?	Y	N

Main problem or reason for this visit?_______________________________________

Insurance__________________ Member Name__________________________ Birthdate________________

Member ID ______________________

Release: I authorize Northwest Vision Center to release any information required for insurance processing. **I understand that I am responsible for all charges and fees that my insurance does not pay.**

Signature (Patient or Parent) ______________________________ Date:______________________