The CEI Foundation Vision Clinic (513-207-6140)

Clovernook Center

Please fill out information as completely as possible and bring to your first office visit

Your Demographic Information

Mr. _____ Mrs. _____ Ms. _____

Your Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _(_____)_____ Work Phone: _(_____)_____

Social Security #: _____ Gender: M F Race: _____

Birthdate: _____ Language: _____ Marital Status: _____

Email Address: _____ Cell Phone: _(_____)_____

Your employment Information

Employer: _____

Employer Address: _____

City/ST/Zip: _____

Your Emergency Contact Information

Contact Name: _____ Phone: _____ Relation: _____

Contact Name: _____ Phone: _____ Relation: _____

Your Physician Information

Family Physician: _____ Phone: _____

Cardiologist: _____ Phone: _____

I agree to treatment deemed necessary by the physician and authorize the release of any medical information required by the involved parties deemed necessary.

_____

Signature of patient/patient representative Date

<u>Please bring a W2 form, last year's tax return or current pay stub</u>**

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First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____

Drug Allergies: ___ Yes. ___ No. If yes, describe: _____

Please check <u>Yes</u> or <u>No</u> if <u>YOU</u> have ever had any of the following:

	Yes	No	When Diagnosed	Current Treatment
LUNGS:				
Asthma/Emphysema/COPD				
Tuberculosis				
Sarcoidosis				
HEART:				
High Blood Pressure				
Low Blood Pressure				
Congestive Heart Failure				
Heart Problems				
Elevated Cholesterol				
Raynaud's Disease				
GASTROINTESTINAL:				
Jaundice/Hepatitis				
Ulcers/Bleeding				
MUSCULO-SKELETAL:				
Arthritis or Osteoporosis				
BLOOD DISORDERS:				
Anemia				
Bleeding Disorder				
Hepatitis A, B, or C				
H.I.V.				
Blood Transfusion				
ENDOCRINE:				
Diabetes				
Thyroid Problems				
NERVOUS SYSTEM:				
Hearing Problems				
Fainting or Dizziness				
Migraine Headaches				
Convulsions/Epilepsy/Seizures				
Stroke/Paralysis/TIA				
Alzheimers/Parkinsons/Dementia				
Other				
PSYCHIATRIC:				
Depression				
GENITOURINARY:				
Kidney Disease				
Prostate Condition				
Pregnant Now?				
EYE HISTORY:				

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Cataract History				
Glaucoma History				
Retinal Problems				
Other				

Please list any Eye and General surgical procedures:

Type of Surgery	Date	Reason

Please list all prescribed and over-the-counter medications and vitamins:

Name of Prescription/Medication	Taken for what condition	Dosage	Frequency

Please check Yes or No if a member of your family has ever had any of the following:

Family History	Yes	No	Relationship
Corneal Disease			
Cataracts			
Glaucoma			
Retinal Detachment/Retinal Disease			

The above questions provide our health care providers information that may assist in providing you the best possible care. If you have any questions regarding how to respond to these questions, please ask the staff for assistance.

I have answered the above questions to the best of my knowledge.

_____

Patient's Signature (Or person authorized to sign for patient) **Date**

_____

Physician's Signature **Date**

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Authorization for Release of Information

1574 Claretta Drive
Cincinnati, Ohio 45231
Phone: (513) 207-6140

Patient Name: _____ Acct#: _____

Please List all individuals you authorize to receive information about your care:

Individual's Name	Relationship	Phone Number

_____

Patient's Signature Date

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Patient Written Waiver

I, _____ , understand that the care I receive from the The CEI Foundation Vision Clinic at Clovernook Center will be provided at no cost, I fully understand that by giving my consent to the provision of ophthalmologic and/or optometric diagnosis, care, and treatment at no cost, I have relinquished my right to legal action against the providing doctor(s) and his/her/their practice for any problem related to that treatment pursuant to the provision contained in §2305,235 of the Ohio Revised Code, unless the problem is a result of willful or wanton misconduct on the part of the treating doctor:

In consideration of the free health care services received on _____(date), I, or myself and anyone entitled to claim through me, do hereby waive and release from liability any persons associated with this event and the following groups and the officers, directors, employees, affiliates and/or assigns of the following groups: Cincinnati Eye Institute, The Cincinnati Eye Institute Foundation, The Clovernook Center and any other named or unnamed sponsors associated with this event.

I acknowledge that I have been informed of and understand the provisions of Ohio Revised Code §2305.235 prior to receiving treatment,

By giving informed consent to the provision of the diagnosis, care or treatment I, _____ fully acknowledge that I cannot bring a tort or other civil action, including an action on a medical or other health related claim, against the treating doctor(s) unless the action or omission of the treating doctor(s) constitutes willful or wanton misconduct.

I grant to The Cincinnati Eye Institute Foundation and its agents the right to use my picture, voice, name and other reproductions of my physical likeness in connection with advertising or publicizing its activities in all forms of media in perpetuity.

I acknowledge that I am of sound mind and free from duress and any undue influence. I have had the opportunity to read and fully understand the terms and conditions contained in this consent and by signing below I agree to said terms and conditions.

_____

PRINT NAME OF PATIENT

_____ _____

Signature Date