ARENA EYE SURGEONS
PATIENT INFORMATION

OFFICE USE ONLY

Acct. No.______________ Doctor________________________________ Dx____________________ Date of Appt.______________

PATIENT INFORMATION *PLEASE PRINT*

Patient Sex: Male Female **Marital Status**: S M D W

Patient Name: ____________________________ (FIRST) ________ (MI) ________________________________ (LAST)

Address: ____ Apt .__________ Home Phone: _______-______-___________

City, State, Zip Code: ____ Work Phone: _______-______-___________

Social Security No.: ________________________ Date of Birth: _____________ Cell Phone: _______-_______-___________

E-Mail Address (optional):__________________________________ Occupation:_______________________________ FT / PT

Patient Employer: ____________________________________Employer Address:____

Family Medical Doctor:_______________________________ ____

Who may we thank for referring you to our office? ____

SPOUSE INFORMATION (OR GUARANTOR IF PATIENT IS MINOR) *PLEASE PRINT*

Name: ______________________________________Date of Birth: _____________ Social Security No.:____________________

Employer:____ Employer Phone: _________-__________-___________________

Employer Street Address: _________________________________ City, State, Zip:______________________________________

EMERGENCY CONTACT (OTHER THAN SPOUSE) *PLEASE PRINT*

Name:____ Phone Number: ______-______-____________________

Relationship to Patient: ______________________________________

INSURANCE INFORMATION: *RECEPTIONIST WILL COPY ALL INSURANCE CARDS*

PRIMARY

Insurance Co.:____ Subscriber Name:____________________________________

Subscriber Date of Birth:_______________________________ Relationship to Patient:_______________________________

Policy #:____ Group #:____

SECONDARY

Insurance Co.:____ Subscriber Name:____________________________________

Subscriber Date of Birth:_________________________________ Relationship to Patient:______________________________

Policy #: ____ Group #: ____

Treatment received by the **ARENA EYE SURGEONS** may include, but is not limited to, dilation, laser surgery, and diagnostic procedures. Vision may be temporarily impaired for driving and or operation of mechanical equipment. Should you have any questions concerning this, please feel free to ask the technician.

Revised 2/23/2010

ARENA EYE SURGEONS
PATIENT HISTORY/MEDICATION FORM

Patient Name: ______________________________ **DOB:** ______________ **Date:** ________________

MEDICATION (including over the counter and herbal)	**STRENGTH**	**DOSAGE**	**FREQUENCY (once a day/twice a day, etc.)**

Do you have allergies to any medications? (please list below)

Medications: ____

____

____

____

____

____

____

____

Signature: ____________________________________ **Date:** ________________________

Signature: ____________________________________ **Date:** ________________________

ARENA EYE SURGEONS REVIEW OF SYSTEMS FORM

Patient Name: DOB:

Do you have any of the following problems?			
System	Yes/No	Date Diagnosed	Condition/Current Treatment/Surgery
EYE: cataracts, glaucoma, macular degenerations, retina problems, injury or surgery, amblyopia or muscle problems	☐ YES ☐ NO		
CONSTITUTIONAL (general): fever, weight loss	☐ YES ☐ NO		
EARS/NOSE/MOUTH/THROAT: dry mouth, hearing loss	☐ YES ☐ NO		
CARDIOVASCULAR (heart): high blood pressure, high cholesterol, arrhythmia, bypass, congestive failure, heart attack	☐ YES ☐ NO		☐ Cardiologist ____________________
>Pacemaker/Defibrillator/Stent	☐ YES ☐ NO		
RESPIRATORY (lungs): bronchitis, asthma, emphysema, MRSA, COPD	☐ YES ☐ NO		☐ Oxygen How many hours _______ ☐ Sleep Apnea
GENITOURINARY: bladder, prostate, kidneys, dialysis	☐ YES ☐ NO		☐ YES ☐ NO Flomax ☐ Previously Used D/C _________
GASTROINTESTINAL (stomach): ulcers, heartburn, reflux	☐ YES ☐ NO		
DERMATOLOGIC (skin): skin disorders, rosacea, MRSA	☐ YES ☐ NO		
MUSCULOSKELETEL (joints): arthritis, bone problems	☐ YES ☐ NO		
NEUROLOGICAL (nerves): stroke, MS, Parkinson's, headaches, weakness	☐ YES ☐ NO		
PSYCHIATRIC: depression, anxiety	☐ YES ☐ NO		
ENDOCRINE (hormones): thyroid, diabetes	☐ YES ☐ NO		
>Do you take insulin or oral diabetes meds?	☐ YES ☐ NO		Year of diabetes diagnosis:
ALLERGIC/IMMUNOLOGIC (allergies/immunity): sinus, seasonal allergies, lupus	☐ YES ☐ NO		
HEMATOLOGIC/LYMPHATIC (blood/lymph): bleeding tendencies, clots, HIV/AIDS, hepatitis	☐ YES ☐ NO		Type: Treatment: Physician:
CANCER	☐ YES ☐ NO		Type:
>Are you allergic to any drugs:	☐ YES ☐ NO		List:
>Are you allergic to latex:	☐ YES ☐ NO		

FAMILY HISTORY:		Family Member
Cataracts	☐ YES ☐ NO	
Glaucoma	☐ YES ☐ NO	
Macular degeneration	☐ YES ☐ NO	
High blood pressure	☐ YES ☐ NO	
Diabetes	☐ YES ☐ NO	

SOCIAL HISTORY:	
Alcohol use	☐ YES ☐ NO
Tobacco use	☐ YES ☐ NO
Drug use (recreational)	☐ YES ☐ NO

Patient's Signature/Date: ____

Tech initials/Date: ______________________ Doctor initials/Date: ______________________

Tech initials/Date: ______________________ Doctor initials/Date: ______________________

ARENA EYE SURGEONS
www.ArenaEyeSurgeons.com

262 Neil Ave.
Suite 320
Columbus, Ohio 43215
614.228.4500
614.221.0138 Fax

Peter J. Utrata, M.D.
Robert P. Bennett, M.D.
Curtin G. Kelley, M.D.
John R. Stechschulte, M.D.
Karl S. Pappa, M.D.
Carrie A. Lembach, D.O.
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551 W. Central Ave.
Suite 101
Delaware, Ohio 43015
740.368.5500
740.368.5599 Fax

InFocus@ArenaEyeSurgeons.com

Our practice offers two types of office eye exams, medical and routine. Insurance companies handle medical eye exams and routine eye exams differently. Please read this form; select the type of examination you expect today and sign below.

MEDICAL EYE EXAM

- Care of eye disease such as cataracts, retinal problems or glaucoma.
- Evaluation of eye pain, redness, light sensitivity or marked vision changes.

ROUTINE EYE EXAM

- Patient believes she/he has healthy eyes and wants a full eye examination.
- Patient needs glasses or a change in prescription strength.
- Patient's insurance pays for an annual or every two year healthy eye exam.

IMPORTANT FACTS TO KNOW

- The measurement for a glasses prescription is called a refraction.
- Refractions are **not** covered by Medicare and are to be paid for by the patient at the time of service.
- Our office does **not** submit claims to any vision plans.
- Our ophthalmologists are **not** providers for any vision insurance plans (i.e.; CVC with United Healthcare, VSP/Vision Service Plan, Cole Vision, Vision One, etc.).
- Our optometrist is a provider for Eye Med only.
- Contacts and contact lens fittings are to be paid for by the patient at the time of service.

REFERRALS

- Many insurance companies require the patient to obtain a written referral from his/her primary care physician (PCP). If you have an HMO policy or if a PCP is listed on your insurance card, you need a referral to see our doctors (just as you need for any other specialist you visit). You must have this referral **before** you see the doctor. If you have not obtained your referral, please use our phone and call your PCP to obtain your referral.
- The referral can be faxed to our downtown office 614.221.0138 or our Delaware office 740.368.5599.

PLEASE INDICATE THE TYPE OF EXAM YOU ARE REQUESTING TODAY:

☐ ***Medical Eye Exam*** -

Referral required? ☐ Yes ☐ No

I have my referral. ☐ Yes ☐ No

☐ ***Routine Eye Exam***

☐ Self pay ☐ Submit to Eye Med Insurance only

☐ ***Contact Lens Exam***

☐ ***Contact Lens Fitting***

PATIENT SIGNATURE:_______________________________________DATE:________________

Medical Office Receptionist will make a copy if requested.

Revised 2/1/2010

VISUAL ASSESSMENT

PATIENT NAME : ___________________________DOB: _______________________________

VISUAL FUNCTIONING

Do you have difficulty, with your glasses, doing the following activities ?

1. Reading small print, such as newspaper print, medicine bottles or telephone book? ☐ YES ☐ NO
2. Reading large-print books? ☐ YES ☐ NO
3. Reading traffic signs or street signs at a distance? ☐ YES ☐ NO
4. Difficulty driving at night ? ☐ YES ☐ NO
5. Difficulty driving during the day? ☐ YES ☐ NO

SYMPTOMS

Have you been bothered by:

1. Rings or halos around lights? ☐ YES ☐ NO
2. Glare caused by headlights or bright lights? ☐ YES ☐ NO
3. Decreased color vision? ☐ YES ☐ NO

Visual Goal

1. Do you dislike wearing glasses? ☐ YES ☐ NO
2. Do you wish to eliminate the need for glasses? ☐ YES ☐ NO
3. Do you dislike the idea of wearing reading glasses? ☐ YES ☐ NO
4. Are you aware that there are implants available to you to help eliminate or decrease the need for glasses after surgery? ☐ YES ☐ NO

SIGNATURE____ DATE_________________

ARENA EYE SURGEONS

I, ____________________________ (Print Name of Patient), acknowledge that I received a copy of ARENA EYE SURGEONS' Notice of Privacy Practices.

____
Signature of Patient or Personal Representative

____
Date

I, ____________________________ (Print Name of Patient), acknowledge that I declined a copy of ARENA EYE SURGEONS' Notice of Privacy Practices.

____
Signature of Patient or Personal Representative

____
Date

ARENA EYE SURGEONS
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 8, 2010, and will remain in effect until we replace it.

We reserve the right to change our privacy practices as long as it complies with applicable law. If we make any material revision to this Notice, we will post a copy of the revised Privacy Notice in each of our offices which will specify the date on which the revised Notice is effective. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following categories describe some examples that our practice may use and disclose your medical information. These are some examples and therefore, not every permitted use and disclosure is listed.

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information about you in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us written authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Appointment Reminders: We may use and disclose your health information to provide you with appointment reminders (such as voicemails or letters).

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Person Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically and reasonably do so. You must make a request in writing to obtain access to your health information. If you request an alternative format, we may charge a cost-based fee for providing your health information in that format. You may obtain a form to request access by using the contact information listed at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years or such shorter time as you may specify. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions (except to the extent required by the Recovery Act for certain cash transactions); but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you have the right to request a paper copy of this Notice.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a compliant with us or with the U.S. Department of Health and Human Services.

Contact Officer: Mary DeLong Telephone: 614.228.4500 Fax: 614.221.0138
Address: Arena Eye Surgeons, 262 Neil Avenue, Suite 320, Columbus, OH 43215
(Notice amended 6/2/04) (Notice amended 7/10/05) (Notice amended 2/8/2010)

ARENA EYE SURGEONS

www.**ArenaEyeSurgeons**.com

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Curtin Kelley, MD | Carrie Lembach, DO
Kiran Sajja, MD
Gregory DeNaeyer, OD
InFocus@ArenaEyeSurgeons.com

551 W. Central Ave.
Suite 101
Delaware, Ohio 43015
740.368.5500
740.368.5599 Fax

Welcome to Arena Eye Surgeons,

We trust your first visit with us will meet or exceed your expectations. If any part of your experience with us is not excellent, please contact me. My phone number is 614.228.4500 and my email address is mdelong@ArenaEyeSurgeons.com.

How did you find out about your physician and Arena Eye Surgeons?
Check the appropriate box below:

☐ Family Member or Friend ______________________________
(Please provide a name so we may send a "thank you".)

☐ Eye Doctor ______________________________ ☐ MD ☐ OD

☐ Other Type of Physician ______________________________ (name)

☐ Health Insurance Plan ______________________________ (name)

☐ Arena Eye Surgeons' Staff ______________________________ (name)

☐ Website

Arena Eye Surgeons Website ☐

Other Website ☐ ______________________________
(Please provide name)

☐ Yellow Pages / White Pages Book

☐ YellowPages.com

☐ Internet Search Engine ______________________________ (name)

☐ Publication ______________________________ (name)

☐ Community Event/Health Fair ______________________________

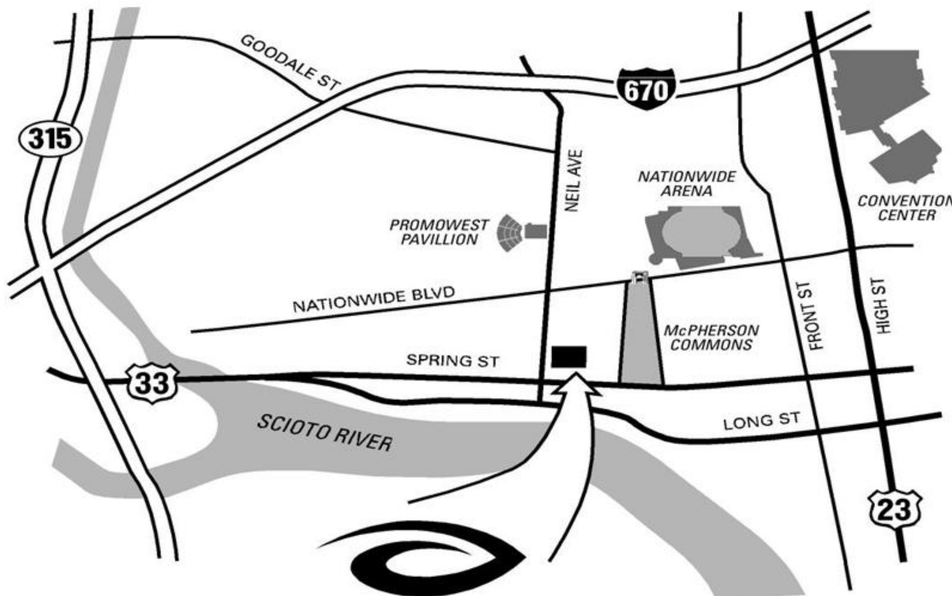
☐ Other (Please List) ______________________________

Please bring this completed survey to your appointment. Thank you for choosing Arena Eye Surgeons as your eye health care provider.

Mary L. DeLong

Mary L. DeLong, MBA
Administrator
Revised 3/2011

Directions to Arena Eye Surgeons At The Eye Center



The Eye Center

262 Neil Avenue
Suite 320
Columbus, Ohio 43215

Phone: 614-228-4500
or
888-372-EYES(3937)

Laser Vision Correction
Ph: 614-228-EYES (3937)

E-mail:
infocus@arenaeyesurgeons.com

FROM THE NORTH

- South on I-71 to I-670 west. Exit at Goodale/Neil Avenue. Turn Left at the intersection onto Neil Avenue. Go 1/2 mile on Neil Avenue. The Eye Center is on the left before Spring Street.
  -OR
- South on OH-315. Exit at Neil Avenue/Airport. Merge right onto the Neil Avenue exit that turns into the Goodale/Neil Connector. Turn right at the intersection onto Neil Avenue. Go 1/2 mile on Neil Avenue. The Eye Center is on the left before Spring Street.

FROM THE SOUTH

- North on I-71 to OH-315 to US 33/Long Street exit. Turn right at the intersection onto Long Street. Turn left onto Neil Avenue. The Eye Center will be on your right within 50 yards.

FROM THE EAST

- West on I-70 to I-71 north (exit 101A toward Cleveland). Merge onto I-670 west. Exit at Goodale/Neil Avenue. Turn left at the intersection onto Neil Avenue. The Eye Center is on the left before Spring Street.

FROM THE WEST

- East on I-70 to OH-315 north. Exit at US 33/Long St. Turn right at the intersection onto Long Street. Turn left onto Neil Avenue. The Eye Center will be on your right within 50 yards.
  -OR
- East on I-670. Exit at Neil Avenue. Turn right at the intersection onto Neil Avenue. Go 1/2 mile on Neil Avenue. The Eye Center is on the left before Spring Street.

PARKING OPTIONS:

- There is a parking garage just north of The Eye Center on Neil Avenue.
  Please bring your parking ticket so we may validate it.
- There is metered parking available along nearby streets.
- You may also use the valet parking at the entrance to our building. The charge is a flat fee of $5.00 and is not eligible for validation. Valet Parking hours are Mon.-Fri. 7am to 6 pm.

www.arenaeyesurgeons.com