Mid Ohio Eye

Physicians & Surgeons

The difference is clear!

Louise A. Doyle, D.O. • Heather C. Koelling, M.D.
Ashley N. San Filippo, M.D. • Elizabeth J. Cockerill, O.D.

Patient Registration Form

PLEASE PRINT

Patient Name _____ (LAST) _____ (FIRST) _____ (MI) **DOB** ____/____/_____

SSN: _____ **Gender:** [ ] M [ ] F **Marital Status:** [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Demographic Information

Race: [ ] American Indian/Alaskan Native [ ] Asian [ ] African American [ ] Caucasian
[ ] Hispanic/Latino [ ] Native Hawaiian or Other Pacific Islander [ ] Other _____

Patient Contact Information

Mailing Address:		
City:	State:	Zip:
Email Address:	Home Phone: (____) _____ - _____	
Employer Name:	Cell Phone: (____) _____ - _____	
Employer Address:	Work Phone: (____) _____ - _____	Ext: _____
City:	State:	Zip:

Emergency Contact Name: _____ Relation: _____ Phone: (____) _____ - _____
Name: _____ Relation: _____ Phone: (____) _____ - _____

For Minor Patients (If Applicable)

Responsible Party:		Relation:	
Address:		Phone Number: (____) _____ - _____	
City:	State:	Zip:	DOB: ___/ ___/ _____

Doctor Information

Primary Care Physician: _____ Location: _____

Eye Care Provider: _____ Location: _____

Consent for Treatment Involvement

Please list family members or friends with whom we may discuss your treatment and medication decisions or payment for your care: [ ] No One [ ] Yes. List name and relationship: _____

Text Messaging and Voice Mail Consent

Text Message: [ ] YES [ ] NO Voice Mail: [ ] YES [ ] NO Messaging could include non-medical information and appointment reminders. Please note we will ONLY communicate for medical reasons as outlined by HIPAA.

By signing below:

1) I acknowledge that I have been informed of the HIPAA Privacy Practices and have been offered a copy;
2) I acknowledge that I have been informed of the Patient Financial Policy and have been offered a copy;
3) I am aware that I can obtain copies of these documents in the office and on the Mid Ohio Eye website;
4) I agree that all information given above is true to the best of my knowledge;
5) I agree that I am responsible for notifying Mid Ohio Eye of any changes in my demographic information, and understand and agree to allow up to 2 weeks for Mid Ohio Eye to update any changes made to my preferences;
6) I authorize my insurance benefits be paid directly to the physician, and I authorize my insurance company to release any information required to process my claims.

How were you referred to us?

[ ] Doctor Referral (please list) _____ [ ] Insurance [ ] TV/Radio [ ] Social Media
[ ] Friend / Relative _____ [ ] Other _____

Patient Signature: _____ Date: _____