Diplomates of the American Board of Ophthalmology and Optometry

KERRY T. GIVENS, M.D.
DAVID S. WILLIAMS, M.D.
LEE A. KLOMBERS, M.D.
OLGA M. WOMER, O.D.
LISA J. KOTT, O.D.
KATHRYN A. ANDREWS, O.D.

2108 Harrisburg Pike, Suite 100
Lancaster, PA 17601-3200
Phone 717-544-3900
FAX 717-544-3910
www.campuseyectr.com

222 Willow Valley Lakes Drive
Suite 1800
Willow Street, PA 17584
Phone 717-464-4333

NEW PATIENT INTAKE FORM

Today's Date: ________________ Urgent / First Available **(circle one)**

PATIENT INFORMATION

Last Name: ____________________ **First Name:** ____________________ **Middle:** ______________

Salutation: (circle one) Mr. / Mrs. / Ms. / Miss

Marital status: (circle one) Single / Married / Divorced / Separated / Widowed

Home #: (__)______________ **Cell #:** (__)______________ **Work #:** (__)______________

Date of Birth: __/__/____ **Age:** _____ **Sex:** Male / Female **(circle one)**

Street Address: ______________________________ **P.O. Box:** ____ **SS#:** ___/__/______

City: ________________ **State:** ________ **ZIP code:** ________ **Physician:** __________________

Referred by: ______________________ **Phone #:** ______________ **Fax #:** ________________

Doctor's Signature: ____________________________________

Reason for referral: ____

INSURANCE INFORMATION

Primary: ______________________ **Policy #:**____________ **Group #:**________ **Co-pay:**_______

Secondary (if applicable): ______________________**Policy #:** ____________ **Group #:**________

PLEASE FAX RECORDS TO: (717) 544-3910

*******Please include referral request for Plaquenil*******

Please have patient bring:

- Medication List
- New patient form that will be mailed to them
- Referral if needed to see Campus Eye Center
- Insurance cards

Patient is responsible for co-pay when checking in.

FOR **FRONT OFFICE** USE ONLY:
Fax received: ______________
Patient scheduled: ___________

w/ Provider: KTG or DSW

If there's a scheduling preference?: M T W T F AM or PM (please circle)