Campus Eye Center

2108 Harrisburg Pike, Suite 100
P.O. Box 3200
Lancaster, PA 17604-3200
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

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.

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 **Sex:** Male / Female **(circle one)**

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

Home #: (___)_____ **Cell #: (___)**_____ **Work #: (___)**_____

Date of Birth: ___/___/_____ Age: _____ SS#: ____/ ____ /_____ Email: _____

Street Address: _____ **P.O. Box: _____**

City: _____ **State:** _____ **ZIP code:** _____ **Physician: Lee A. Klombers, MD**

Referred by: _____ **Phone #:** _____ **Fax #:** _____

Reason for referral: _____

INSURANCE INFORMATION

Primary: _____ **Policy #:**_____ **Group #:**_____ **Co-pay:_____**

Subscriber Name: _____ **Subscriber DOB: ___/___/_____**

Secondary (if applicable): _____**Policy #:** _____ **Group #:**_____

Subscriber Name: _____ **Subscriber DOB: ___/___/_____**

PLEASE FAX RECORDS TO: (717) 544-0349

_____ Letter of referral
_____ Insurance cards (front and back) **We <u>DO NOT</u> participate with UPMC for You, UHC Community Plan, Amerihealth Caritas or Gateway**
_____ Medication list
_____ 2 most recent office notes
_____ Last 2 lab results
_____ MRI/CT scans/Carotid Ultrasounds
_____ Angiogram/Arteriogram brain, orbits, neck
_____ Visual fields
_____ Color OCT's (**<u>Please mail, have patient hand carry, or email to: smcglinchey@campuseyectr.com</u>**)

Bring insurance cards, co-pay, and referral if needed
Please fax intake form to (717) 544-0349