Campus Eye Center

www.campuseyectr.com
2108 Harrisburg Pike, Suite 100
Lancaster, PA 17601
Phone: 717-974-9661
Fax: 717-974-9669

222 Willow Lakes Drive
Willow Street, PA 17584
Phone: 717-464-4333
Fax: 717-464-4933

Diplomates of the American Boards of Ophthalmology and Optometry
Kerry T. Givens, MD
David W. Williams, MD
Lee A. Klombers, MD
Olga M. Womer, OD
Lisa J. Kott, OD

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

***WE DO NOT PARTICIPATE WITH MEDICAID OR ANY DUAL OPTION PLANS ***

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

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

PLEASE FAX RECORDS TO: (717) 974-9669

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.

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

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)

updated 7.27.22