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

NEW PATIENT INTAKE FORM

Today's Date: _____ Urgent (within 2 weeks) / First Available (circle one)

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **Middle:** _____

Salutation: (circle one) Mr. / Mrs. / Ms. / Miss **Sex:** Male / Female / Other (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:** Kiran Turaka, M.D.

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

Reason for referral: _____

INSURANCE INFORMATION

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

Subscriber Name: _____ **Subscriber Date of Birth:** _____

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

Subscriber Name: _____ **Subscriber Date of Birth:** _____

PLEASE FAX RECORDS TO: (717) 974-9676

- _____ Letter of referral _____ Copy of Photoscreening _____ Medication list _____ 2 most recent office notes
- _____ Last 2 lab results (within 1 year) _____ MRI / CT scans _____ Angiogram/Arteriogram brain, orbits, neck
- _____ Visual fields _____ Color OCT's (Please mail or email to: smcglincey@campuseyctr.com)

_____ Insurance cards (front and back) We **DO NOT TAKE ANY MEDICAID PLANS**, United HealthCare Or Highmark Community Blue HMO

Returned Phone Call w/ Appt info?

YES _____ NO _____