



[www.campuseyectr.com](http://www.campuseyectr.com)  
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**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 (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: Lee A. Klombers, 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) 544-0349

\_\_\_\_ 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@campuseyectr.com](mailto:smcglincey@campuseyectr.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 \_\_\_\_\_