Campus Eye Center

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

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
Kathryn A. Andrews, 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) 544-3910

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

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

FOR **FRONT OFFICE** USE ONLY:
Fax received: _____
Patient scheduled: _____

w/ Provider: KTG or DSW

Patient is responsible for co-pay when checking in.

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

updated 1.13.22