NORTH RIDGEVILLE EYE CARE

DR. CAROL A. NOVAK
7079 AVON BELDEN ROAD NORTH RIDGEVILLE, OHIO 44039
(440)327-2020

First Name_____ MI____ Last Name_____ Date of Birth_____
Address_____ City_____ State_____ Zip_____
Home Phone (____)_____ Cell Phone (____)_____ Okay to receive texts? Yes No
Work Phone (____)_____ Occupation_____ Employer/School_____
Email Address_____ Okay to receive emails? Yes No
Spouse/Guardian's Name_____
Who may we thank for referring you to this office?_____

TO GIVE YOU A MORE THOROUGH EXAM, PLEASE **CIRCLE** ANY OF THE FOLLOWING PROBLEMS YOU ARE CURRENTLY EXPERIENCING:

Blurred Vision	Diabetic	Double Vision	Dry Eyes	Eye Pain/Soreness
Headaches	Itching Eyes	Red Eyes	Sandy/Gritty Feeling	Sleep Apnea
Spots/Floaters	Tired Eyes	Watery Eyes	Other_____	

Date of Last Vision Exam_____ Date you received present glasses_____

Do you currently wear contact lenses? Yes No Soft/Gas Permeable
Are you interested in learning more about the benefits of contacts or refractive surgery? Yes No
Do you work with a computer? Yes No Hours per day_____

Do you use any tobacco products? Please Circle One Currently Former Never

MEDICATIONS CURRENTLY TAKING AND DOSAGES:_____
_____

MEDICATION ALLERGIES_____

FAMILY PHYSICIAN NAME_____ PHONE_____
SPECIALIST/OTHER PHYSICIAN NAME_____ PHONE_____

PLEASE LIST ANY **FAMILY MEMBERS** WITH THE FOLLOWING PROBLEMS:
(Father, Mother, Sister, Brother, Son, Daughter, Maternal/Paternal Grandparent, Aunt, Uncle)

Diabetes_____ Cataracts_____
Glaucoma_____ Macular Degeneration_____

INSURED NAME (FINANCIALLY RESPONSIBLE PERSON/PARENT)
First Name_____ MI____ Last Name_____
Insured Party Date of Birth_____ Social Security #(Last 4 digits only)_____
Vision Insurance Company _____ Medical Insurance Company_____
ASSIGNMENT & RELEASE: I hereby assign my insurance benefits to be paid directly to N. Ridgeville Eye Care, Inc. I am financially responsible for non-covered services. I also authorize this office to release any medical information deemed necessary by my insurance and have been provided its PRIVACY POLICY.
SIGNED (Patient or Parent, if minor)_____ Date_____