THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

OSU Department of Ophthalmology
Havener Eye Institute
614-293-8116

YOUR APPOINTMENT:

☐ **A scheduling representative will contact you to schedule your appointment.**

Date: _____

Time: _____

With Dr. _____

Location:
☐ Eye & Ear Institute (Main Office):
915 Olentangy River Rd. 5th Floor
Columbus, OH 43212

☐ Dublin:
Dublin, OH 43016
6435 Post Rd.

☐ Westerville:
484 County Line Rd. Ste 240
Westerville, OH 43082

WELCOME TO OSU OPHTHALMOLOGY!

OSU Eye Physicians and Surgeons, LLC welcomes you to our practice. Our practice consists of a group of Ophthalmologists who specialize in Comprehensive and general eye health, Corneal & External eye disease, Cataract surgery, Glaucoma, Neuro-Ophthalmology, Ocular Oncology, Orbital/Oculoplastics and Reconstructive surgery, Vitreoretinal eye diseases and conditions. Optometrists that specialize in the refractive needs of our patients with complex eye conditions. We believe in providing you with the finest patient care and ensuring that all areas of concern are satisfied.

PREPARE FOR YOUR VISIT

PRE – REGISTRATION

A Pre-Registration Specialist will contact you at the phone number provided by your doctor. This process will take approximately 10 minutes and will streamline the check-in process the day of your appointment.

Have the following information on hand for pre-registration:

- Your driver's license or state-issued identification
- Insurance card
- Emergency contact information
- The name and address of the provider who is referring you
- Appointment date and time
- Method of payment

ARRIVING FOR YOUR APPOINTMENT

** If **Visitor Restrictions** are in place at the time of your visit, visitors will be asked to wait outside the building during your visit. Exceptions to this restriction are assessed on a case by case basis.*

Arrive no sooner than 5-10 minutes before your scheduled appointment time unless you are contacted and instructed to do otherwise. Be prepared to give the following to the Front Desk Associate at the time of check-in:

- **Completed New Patient paperwork included in this New Patient Welcome Pack**
  - If you are already a patient at OSU and have MyChart, much of this information will already be in your chart. However, if you have never been to the Ophthalmology Department, some eye related information may not be included in your chart. So, please be sure to complete the form in its entirety.
  - If you do not have MyChart and are interested in signing up, please mention it at the time of your Pre-Registration.
- **Driver's license or state-issued identification**
- **Insurance card** (a list of insurances we accept can be found at: wexnermedical.osu.edu/patient-and-visitor-guide/insurances-we-accept)
- **Payment (if applicable) in the form of cash, check or credit card (we accept Visa and Mastercard)**
  - Please note: ***Co-payments and self-pay balances are due at the time of service***

WHAT TO EXPECT DURING YOUR APPOINTMENT

**** Both of your eyes may be dilated for this examination. You may want to bring sunglasses and make arrangements to have someone drive you home from your appointment.***

* Bring any recent CT/MRI scans or reports if they may be related to your visit.

As you will be seeing specialist, **please plan to spend 2 - 4 hours in the office.** Your physician will spend as much time as needed with you, but keep in mind:

- **Emergency patients are very common in our practice and may need to be seen before already scheduled patients due to urgency. As a result, you may experience a wait time. We will do our best to keep you apprised of any delays, and apologize in advance for any inconvenience this may cause you as we do understand how frustrating this can be.**
- **Specialized testing is often performed at the time of your visit**
- **You may be seen by a resident or fellow before your physician during your visit**

***If you are a diabetic or use oxygen, please prepare for potentially long wait times**

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PATIENT QUESTIONNAIRE

_____ , _____ / / _____ _____

Last Name **First Name** **Date of Birth** **Sex**

Referred By: _____ **Preferred Pharmacy:** _____

Marital Status: Married Divorced Separated Widowed **Located at:** _____

Hobbies: _____ **Occupation:** _____

• Reason for visit • (Brief explanation of the problems that bring you to our office)

_____

_____

_____

_____

• Allergies •

Drug Allergies:	Reaction:

Drug Allergies:	Reaction:

• Medications • (Please list **ALL** medications you are currently taking, including eye drops, supplements and over the counter medications)

☐ **NONE**

Name of Medication	Dose & Frequency

*If more space is needed list on a separate sheet

• Personal Medical History •

Eye History: ☐ **NONE**

Condition	Specify	Treatments	Date
Cataracts			
Cornea Problems			
Glaucoma			
Macular Degeneration			
Blurred vision			
Eye Pain			
Dry Eye			
Eye Injuries			
Other			

Diabetes:	**Yes No**	**Type I Type II**	**Insulin Non-insulin**	**Year diagnosed:**	**Last A1c:**
	(Circle one)	(Circle one)	(Circle one)		

Check one:	Y	N	Date or Duration	Specify
Allergies				
Alzheimer's disease/Dementia				
Anemia/Bleeding Problems				
Anxiety				
Arthritis (Osteo/Rheumatoid)				
Asthma/Bronchitis				
Autoimmune Disease				
Blindness				
Blood Transfusion				
Cancer				
Depression				
Emphysema/COPD				
Epilepsy/Seizures				
Kidney/Urinary Problems				
Ulcers/Stomach Problems				
Osteoporosis				
Heart Condition/CVD				
Hepatitis A, B, &/or C				
High Blood Pressure				
HIV/AIDS				
Lupus				
Migraines				
Sickle Cell Anemia				
Stroke/TIA				
Thyroid Disease				
Tuberculosis (TB)				
Other				

• Surgical History •

Eye Surgeries / Lasers / Treatments: ☐ **NONE**

Type of Procedure:	Which Eye	Date:	Surgeon/Clinic:	Complications?:

All Other Surgeries: ☐ **NONE**

Type of Procedure: (if applicable indicate right or left)	Date:	Surgeon/Clinic:	Complications?:

Labs, Testing, Imaging & Studies: ☐ **NONE**

Specify	Date	Where Performed:	Contact Number

• Family Medical History •

Check one:	Y	N	Relation:	Specify
Alzheimer's disease/Dementia				
Anemia/Bleeding Problems				
Arthritis (Osteo/Rheumatoid)				
Autoimmune Disease				
Blindness				
Cancer				
Cataracts				
Corneal Problems				
Diabetes				
Heart Conditions/CVD				
Hepatitis				
High Blood Pressure				
Macular Degeneration				
Migraines/Headaches				
Retinal Detachment				
Sickle Cell Anemia				
Stroke				
Thyroid Disease				
Tuberculosis (TB)				

Other:				

• Social History •

History of Tobacco Use: □ **NONE** □ **YES :**
Specify (circle one)**:** **Current Every Day** **Current Some Days** **Occasional** **FORMER**
Type (circle one)**:** **Cigarettes** **Cigars** **Pipe** **Chew/Snuff**
Amount Per Day?: _____ **Approximate Start Date:** _____ **Quit Date:** _____

History of Alcohol Use: □ **NONE** □ **YES :**
How often do you have a drink containing alcohol?:
Specify: **Never** **Monthly or Less** **2-4 Times a Week** **4 or more times a week**
How many drinks containing alcohol do you have on a typical day when you are drinking?:
Specify: **1 or 2** **3 or 4** **5 or 6** **7 or 9** **10 or more**
How often do you have six or more drinks on one occasion?:
Specify: **Never** **Less than Monthly** **Monthly** **Daily or almost Daily**
How many drinks per week of: **Beer:** _____ **Wine:** _____ **Shots of Hard Liquor:** _____

Recreational Drug Use: □ **NONE** □ **YES :**
Specify: **IV Drug Use** **Marijuana** **Cocaine** **Hallucinogenic**

Physical Activity:
On average, how many days per week do you engage in moderate to strenuous exercise (like a brisk walk)?
Specify: **0 Days** **1 Day** **2 Days** **3 Days** **4 Days** **5 Days** **6 Days** **7 Days**
On average, how many minutes do you engage in excersize on this level?:
Specify: **0-10min** **20-40min** **50-70min** **80-110min** **120-140min** **150+min**

Financial Resource Strain:
How hard is it for you to pay for the very basics like food, housing, medical care, and heating?
Specify: **Very Hard** **Hard** **Somewhat Hard** **Not very hard** **Not hard at all**

Children's Healthwatch Housing Screening:
In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?
Specify: **YES** **NO**
In the last 12 months how many places have you lived?:_____
In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)?:
Specify: **YES** **NO**

Transportation Needs:
In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?
Specify: **YES** **NO**
In the past 12 months, has lack of transportation kept you from meetings, work, or from

getting things you needed for daily living?
Specify: YES NO

Food Insecurity:

Within the past 12 months, you worried that your food would run out before you got the money to buy more.
Specify: Never true Sometimes True Often True

Within the past 12 months, the food you bought just didn't last and you didn't have the money to get more.
Specify: Never true Sometimes True Often True

Stress:

Do you feel stress – tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time these days?
Specify: Not at all Only a Little To some extent Rather much Very Much

Social Connections:

In a typical week, how many times do you talk on the phone with family, friends, or neighbors?
Specify: Never Once a Week 2 Times a Week 3 Times a week 3+ Times a Week

How often do you get together with friends/relatives?
Specify: Never Once a Week 2 Times a Week 3 Times a week 3+ Times a Week

How often do you attend church or religious services?
Specify: Never 1-2 Times per year More than 4 times per year

Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups?
Specify: YES NO

How often do you attend the clubs or organizations you belong to?
Specify: Never 1-2 Times per year More than 4 times per year N/A

Are you married, widowed, divorced, separated, never married or living with a partner?
Specify: Married Widowed Divorced Separated Never Married Living with a Partner

Intimate Partner Violence:

Within the last year, have you been afraid of your partner or ex-partner?
Specify: YES NO

Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?
Specify: YES NO

Within the last year have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?
Specify: YES NO

Within the last year, have you been raped or forced to have any kind of sexual activity by your Partner or ex-partner?
Specify: YES NO

• Physicians •

Specialty	Name	Phone Number
Primary Care Doctor		
Optometrist		

PARTICIPATE IN YOUR CARE

You're the most important person on your healthcare team!

- **Have a prepared list of questions written down before your appointment so you don't forget to ask**
- **Participate in conversation about your eye care. If you don't understand, ask questions. Your doctors wants you to understand your care so you can work together**
    - **There are many ways for you to communicate to your physician and his/her team, you don't have to wait until your next visit:**
        - **Telephone –** call 614-293-8116. Our telephone operators can send a message to your physicians team to answer any questions or concerns you may have after your visit
        - **Online (OSU MyChart) –** you can send messages to your physician and their team

Questions you would like to address with your doctor today:

• Review of Systems •

Circle all that apply:

General Health:	Chills	Fatigue	Unexpected weight change	
	Activity Change	Profuse Sweating (Daiphoresis)		
Ears, Nose & Throat:	Congestion	Dental Problems	Drooling	Ear Discharge
	Ear Pain	Facial Swelling	Hearing Loss	Mouth Sores
	Nosebleeds	Postnasal Drip	Rhinorrhea (runny nose)	
	Sinus Pain	Sinus Pressure	Sneezing	Sore Throat
	Tinnitus	Trouble Swallowing		Voice Change

Eyes:	Discharge	Itching	Pain	Redness
	Light Sensitivity	Blurred Vision	Floaters	
Respiratory:	Sleep Apnea (C-PAP use?)		Chest Tightness	Choking
	Shortness of Breath		Wheezing	
Cardiovascular:	Chest Pain	Leg Swelling	Palpitations	
Gastro-Intestinal:	Abdominal pain	Abdominal Swelling/distention		Anal Bleeding
	Blood in Stool	Constipation	Diarrhea	Nausea
	Rectal Pain	Vomiting		
Endocrine:	Cold Intolerance	Heat Intolerance	Excessive Thirst (polydipsia)	
	Increased appetite (polyphagia)			
Genitourinary:	Difficulty Urinating		Painful Urination (dysuria)	
	Incontinence (enuresis)		Flank Pain	Genital Sore
	Increased Urination		Decreased Urination	
Musculoskeletal:	Arthritic Pain	Back Pain	Gait Problem	Joint Swelling
	Myalgia (muscle pain)		Neck Pain	Neck Stiffness
Skin:	Color Change		Paleness (pallor)	Rash
	Wound			
Immunological	Environmental Allergies	Immunocompromised		Food Allergies
Neurological	Dizziness	Facial Asymmetry	Headaches	Light-headedness
	Numbness	Seizures	Speech Difficulty	Syncope
	Tremors	Weakness		
Hematology	Adenopathy (swollen lymph nodes)		Bruise Easily/excessive bleeding	
Psychiatric	Agitation	Behavior Problems	Confusion	Decreased Concentration
	Hallucinations	Hyperactivity	Nervous/Anxiety	Self-injury
	Sleep Disturbance	Suicidal Thoughts		

Cancellations & Late Arrival Policy

- We strive to provide the most efficient service to our patients and ask that if you need to reschedule or cancel an appointment that you contact our office at least 24 hours in advance.
  * If you miss an appointment without providing required advanced notice, please be aware that rescheduling that appointment cannot be guaranteed.
- If you are going to be late for an appointment, please call ahead so that your physician and their team can be notified. Keep in mind that they may advise that it may be best to reschedule you appointment.

Referrals & Consultations

- If your insurance carrier requires a referral or authorization for your appointment (usually applies to HMO or POS based policies), it is advised that you contact your primary care provider's office and ask that a referral be sent to your insurance carrier.

- It is the patient's responsibility to know if our physicians are participating providers in your insurance carrier. We do participate in most major insurance carriers, but not all. Because insurance carriers frequently merge and update their provider base, it is recommended that you contact your carrier prior to your appointment.
- If your insurance carrier requires a referral or authorization and you do not have one at the time of your appointment:
    - You can pay in full for all services rendered, or
    - You can reschedule the appointment to allow you to obtain the referral or authorization to minimize out of pocket expenses to you, or
    - We can attempt to contact you doctor's office to obtain the referral for you. However, keep in mind that this is often unsuccessful for many reasons and may ultimately need to reschedule or collect payment.

** If you are unsure if you need a referral or authorization, please refer to your insurance policy or contact your insurance carrier. It is your responsibility to know the terms if your policy; for example the in-network providers, your co-pay and the referral process. Please be sure to obtain any referrals that may be necessary to fulfill the requirements of your policy.*

BILLING + INSURANCE

- **A charge will be assessed for your services. Ultimately, it is the patient or guarantor who is responsible for payment of all charges incurred at the time of your visit.**
- **Self-pay patients (includes patients without insurance, patients unable to provide proof of insurance, and patients being seen as a result of an accident):**
    - Be prepared to pay in full at the time of your visit
    - Financial Assistance Available:
        - Income based assistance is available. If you feel that you may qualify for assistance, contact our office for more information.
    - If you do not qualify for financial assistance, and payment in full is not possible, a $250 base fee will be collected from new patients, and $150 from established patients.
- **$45 will be collected for glasses prescriptions. Payment is expected at the time of service and is not covered by most insurance carriers**
- **Any outstanding balances will be collected at check-in**
- **Specific insurance coverage questions should be directed to your insurance carrier.**
- **You may facility charges from the OSU Wexner Medical Center and charges from your physician for their services.**
    - **If you have insurance, your insurance will be billed and any remaining balance us billed to the patient or guarantor.**

If you have any of the insurances listed below, you must have the required paperwork at the time of service. If you do not have the appropriate authorization, our office may reschedule your appointment to allow you time to meet the obligations required by your insurance policy.

- **BWC** (workers comp): You must bring a copy of a C9 (BWC form that indicates a request from another physician for us to see you) with you and/or the appropriate authorization from your managing physician. The C9 should also include authorization for any diagnostic testing or procedures that may be necessary.

- **TRINITY BGS, MEDICARE COMPLETE, ANTHEM SENIOR ADVANTAGE OR MEDIGOLD:** You must have written approval from your insurance company to be seen. This approval is often referred to as an out-of-network referral or authorization. PLEASE NOTE: We also do not participate with any Medicare Advantage HMO plans.
- **HMO INSURANCES:** You must have a referral from your Primary Care Physician in order for your visit to us to be covered by your insurance. Without the authorization, you will be required to pay for your visit in full at the time service or reschedule in order to allow time for you to obtain the appropriate authorization.

We are sorry for ANY inconvenience but your insurance company requires you to obtain this authorization in order to cover your visit to our office. The referring doctor can usually assist you, but it is ultimately your responsibility to make sure the process is completed.

If all the pieces are not in place, the charges associated with your visit to our office will NOT be paid by your insurance company and WILL be your responsibility. Payment will be expected at the time of service as you check in to see us. If additional testing or procedures are required or recommended during your visit, you may want to discuss these with your physician. Based on the recommendations of your physician, a return appointment could be made to complete the necessary testing or procedures and to allow for you to obtain the appropriate authorizations. If the testing and/or procedures are performed at your initial visit, without contacting your insurance company, the charges will not be covered and you WILL be responsible for payment.

In sharing this information with you, we just want to make sure that you are well informed about how we expect your insurance company will handle your charges. The best way to make sure your charges will be covered is to contact your insurance company and obtain the appropriate authorization for your services with us.

Please let us know if we can answer any questions for you or help you with your authorizations.

Social Work is available on a case by case basis and may be able to assist and provide other solutions.

We are here to assist you with any concerns you may have about your visit with us as well as any account concerns you may have. Please notify our office any medical or financial circumstances that you may have.

Driving Directions

915 Olentangy River Rd. Suite 5000
Columbus, OH 43212

From the North
(Sandusky, Delaware and Cleveland)
Take any major highway to Interstate 270
Take Interstate 270 west toward Dayton
Merge onto State Route 315 south toward Columbus
Take the Goodale Street/Grandview Heights exit
Turn right onto Olentangy River Road
The Eye and Ear Institute will be on your left

From the South
(Circleville, Chillicothe and Cincinnati)
Take any major highway to Interstate 71
Take Interstate 71 to State Route 315 north
Take Goodale Street/Grandview Heights exit
Turn right onto West Goodale Street
Turn right onto Olentangy River Road
The Eye and Ear Institute will be on your left

From the East
(Newark, Zanesville and Pittsburgh)
Take any major highway to Interstate 70
Take Interstate 70 west to State Route 315 north
Take the Goodale Street/Grandview Heights exit
Turn right onto West Goodale Street
Turn right onto Olentangy River Road
The Eye and Ear Institute will be on your left

From the West
(Springfield, Dayton and Indianapolis)
Take any major highway to Interstate 70
Take Interstate 70 east to Interstate 670 east
Take Interstate 670 east to State Route 315 north
Take the Goodale Street/Grandview Heights exit
Turn right onto West Goodale Street
Turn right onto Olentangy River Road
The Eye and Ear Institute will be on your left.