Yoongie E. Min, O.D. ~ Marie E. Schiff, O.D. ~ Melissa R.Vetter, O.D.
2200 W. Henderson Road, Suite A ~ Columbus, OH 43220
(614) 273-2020 ~ FAX (614) 273-4335

PREVIOUS PATIENT REGISTRATION

Date:________________________________

Please fill in your current information:

Patient name____ Age________

Street Address____

City, State, and Zip Code____

Phone numbers: Home_______________Work_______________Cell_______________

Occupation____

Employer____

E-Mail Address____

Main reason for visit ____

Current medications____

Immediate family members who are our patients__________________________________

Vision AND Major Medical Insurance: (circle all that apply)

Anthem (BCBS) **Medical Mutual** **VSP** (Vision Service Plan)
UHC (United HealthCare) **Vision Plus** **Vision Benefits of America**
Medicare **Flora Midwest**

Insured Member's Name and Social Security Number _____________________________

For all other insurance plans, payment is due IN FULL at the time of service. We are not required to bill your insurance carrier for you if we are not a direct provider, but will be happy to provide you with copies of your fees or assist in any way possible. Please remember that most insurance plans do not cover your fees in full. ***You will be responsible for any deductibles, co-payments, or non-covered items at the time of service***. *Thank you for your cooperation.*