LASIK EXPERTS

Welcome to Our Practice **Patient Information Sheet**

Name (Last):_____ (First):_____ (M.I):_____

Address:_____

City:_____ State:_____ Zip Code: _____

Date of Birth: _____/_____/_____ Age:_____ Gender: ☐ Female ☐ Male SSN#:_____-_____-_____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Email: _____

Emergency Contact Name: _____ Phone: (_____) _____-_____ Relation: _____

Family Physician_____ Telephone_____

Address_____

Eye Doctor_____Telephone_____

Address_____

Local Pharmacy_____Telephone_____

Address_____

Patient's Employer_____

Work Address_____

Work Phone Number_____Occupation_____

If Patient is a minor:

Mothers Name_____ Fathers Name_____

DOB_____Social Security#_____ DOB_____Social Security#_____

Address if Different_____ Address if Different_____

_____ _____

Primary Care Insurance Information(we would like to scan your card if not a LASIK patient)

Name of Insurance Company_____Ins Phone Number_____

ID or Policy Number_____Group or Plan Number_____

Address to send claims to _____City_____State_____Zip_____

Subscribers Name_____DOB_____Social Security#_____

Patients relationship to subscriber self_____spouse_____child_____other_____

Secondary Insurance

Name of Insurance Company_____Ins Phone Number

ID or Policy Number_____Group or Plan Number_____

Address to send claims to _____City_____State_____Zip_____

Subscribers Name_____DOB_____Social Security#_____

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How did you hear about us? ☐ Radio/TV ☐ Facebook ☐ Instagram (handle if so:_____)

☐ GOOGLE ☐ Referred by:_____ ☐ Insurance ☐ Physician

Are you considering LASIK surgery? ☐ Fairly recently ☐ Within the past year ☐ Several Years

What is your time frame for having LASIK? ☐ Within a week ☐ Within a month ☐ Other

Medical History

1. **Is there any chance you may be pregnant or nursing?** ☐ Yes ☐ No
2. **Please indicate any eye problem—other than the need for corrective lenses—that you may have** ☐ None

☐ Keratoconus ☐ Corneal disease ☐ Glaucoma ☐ Cataracts ☐ Amblyopia

☐ Injury/Scar ☐ Severe Dry Eye ☐ Retina Detach/Tear ☐ Prism in Glasses ☐ Recurrent Corneal Erosion

☐ Strabismus ☐ Double Vision ☐ Corneal Abrasion ☐ Other, please explain_____

3. **Have you ever had any kind of eye surgery?** ☐ Yes ☐ No
   IF so what kind_____
4. **Do you have or have you ever had any of the following:**

☐ Autoimmune disease (Lupus, Rheumatoid Arthritis, Colitis, Crohn's) ☐ HIV/Aids ☐ Hepatitis B or C

☐ Herpes of the Cornea ☐ Life-Sustaining Implant Device ☐ Keloid Scarring ☐ Diabetes

☐ Tuberculosis ☐ Depression/Anxiety ☐ Hypertension ☐ A fainting episode, please explain:_____

☐ Other diseases or medical condition: _____

5. **List any other surgeries that you have had**_____

6. **Are you presently taking any medications?** ☐ None If so please list_____

_____

7. **Do you have allergies or sensitivities to any of the following?** ☐ None ☐ Latex ☐ Indoor ☐ Food

☐ Pet / Animal ☐ Seasonal ☐ Outdoor ☐ Steroids ☐ Betadine ☐ Adhesive tape ☐ Other, please list:_____

8. **Do you have any allergies to medications?** ☐ None ☐ Yes, please list:_____

9. **Do you experience any of the symptoms?** ☐ Night glares and halos ☐ Itchiness / Scratch

☐ Dry eyes ☐ Rubbing of the eyes

ABOUT YOUR GLASSES

1. **Do you currently wear glasses?** ☐ Yes ☐ No
2. **If yes, do you experience glares or halos at night?** ☐ Yes ☐ No
3. **Do you have difficulty driving at night with your glasses?** ☐ Yes ☐ No
4. **If you know your prescription for glasses, please indicate it below:**

Right eye: _____ Left eye_____

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5. **Do you currently wear contacts?** ☐ Yes ☐ No

If you wear contact lenses, please indicate the following:

6. **Type of contact lenses:** _____
7. **Frequency of use:** _____
8. **How long have you been wearing contact lenses?** _____
9. **When was the last time you wore your contact lenses?** _____
10. **Do you experience glares or halos at night with you contact lenses?** ☐ Yes ☐ No

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1. **I am responsible for providing a referral when required.**
2. **I am responsible to provide ALL payments, including outstanding balances, co-payments, and deductibles when services are rendered.**
3. **I understand that I am financially responsible to pay for any balance not covered by my Primary Insurance or Secondary Insurance, such as co-insurance, co-payment and any other services that are not covered by my insurance plan.**
4. **I authorize the release of any medical information necessary to process an insurance claim.**
5. **I will immediately notify your office of any change in my address, phone number, and insurance information.**
6. **I am responsible to inform you about the complete benefits by my insurance.**

Patient/Guardian Signature_____**Date:**_____

LASIK PATIENTS ONLY

1. What are your reasons for considering vision correction? ☐ Sports ☐ Occupation ☐ Intolerance to contact lenses ☐ Freedom from glasses and / or contact lenses

☐ Other, please explain: _____

2. To better understand your needs, please let us know your favorite leisure activities (Check all activities compromised by your vision): ☐ Driving ☐ Reading ☐ Recreation ☐ Occupational ☐ Computer ☐ Sports ☐ Other, please explain:_____

3. Please indicate the three criteria which are most important in your decision to have vision correction.

☐ Safety of procedure ☐ Provider experience ☐ Cost ☐ Availability of financing ☐ Latest technology ☐ Other, please specify: _____

4. Have you visited other laser vision correction centers? ☐ Yes ☐ No

Please list if yes: _____

Please read the following and initial beside each line to indicate that you have read it. Please free to ask your Surgical Counselor if you have any questions.

_____ **Refractive surgery is not recommended is you are pregnant, plan to become pregnant in the next 2 months, or are nursing.**
_____ **You will not be able to drive home after your surgery; Please arrange transportation.**
_____ **Refractive surgery is not 100% predictable; further treatment may be required.**
_____**Mono-vision is an option that can be discussed with you.**
_____**The pre-op appointment today is approx. 2 hours in length, & the surgery appointment is approx. 2-4 hrs.**
_____**If you are currently a member of the U.S. military forces, or plan to join, please consult with your supervising office and/or local recruiter regarding military policies and procedures post refractive surgery.**

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By signing below, you:

- Acknowledge that you have been informed of the Privacy Practices and agree to receive emailed information, offers, and promotions

- Acknowledge that you have access to a copy of these documents in the center and agree that all information given is true to the best of your knowledge

_____ _____

Signature of Patient or *Personal Representative* **Date**

If personal representative, please print your name and describe your relationship to the patient