Medical History:

Do you have a history of any general medical surgeries? No If yes, please specify**:** _____

Indicate any of the following problems in which you have experienced: (Please answer all)

High Blood Pressure	No	Shortness of Breath	No	Chest Pain	No	
Heart Attack	No	Irregular Heartbeat	No	Seizures	No	Date of last Seizure_____
Asthma	No	Emphysema	No	Bronchitis	No	
Pacemaker	No	Diabetes	No	Thyroid	No	
Arthritis	No	Bladder/Kidney	No	Lupus	No	
Chronic Cough	No	Tuberculosis	No	Hearing Loss	No	
Abdominal Pain	No	Sinus Problems	No	Fatigue	No	
Chrons Disease	No	Hepatitis A	No	Hepatitis B	No	
Hepatitis C	No	STD	No	HIV Positive	No	
AIDS	No	Smoke	No	Packs per day_____		

Other _____

If female, are you pregnant or breast feeding? _____

Please notify staff members if you are pregnant, plan to be, or are presently nursing

Any other health problems we should be aware of? _____

The following may pertain to patients having refractive procedures and will be discussed with you during evaluation.

Reading glasses may be required after refractive surgery.

Contact lenses MUST be removed prior to Complete Eye Exam (Soft lenses 7 days ** Hard/RGP 4 weeks)

Refractive surgery is not 100% predictable. Vision may vary from present prescription.

Vision may be blurred for a week or more after your procedure. Driving and reading may be difficult during this time.

Normal healing period after refractive surgery is 6-8 weeks.

I understand that I can NOT drive myself home the day of the procedure and that my driver must be in the office prior to starting my procedure.

In compliance with HIPAA and Insurance guidelines; Schwartz Laser Eye Center requires an updated History and Physical form annually.

_____ Patient Initials

I understand the fee for the *Determination of Refractive State* in order to provide a written prescription is $50.

_____Patient Initials

I attest that all of the information above is correct to the best of my knowledge. I hereby authorize and consent to Schwartz Laser Eye Center and staff to perform any evaluations necessary during my eye exam or surgical procedures. I understand that all insurance information will be held by Schwartz Laser Eye Center in strict confidentiality and will only be released as part of the standard protocol deemed necessary for insurance billing. I authorize the release of any medical or other information necessary to process any insurance claims. I also request payments of government or insurance benefits either to myself or to the assigned physician or supplier for services described within. **_____ Patient Initials**

I understand that payment is expected in full on the day of my procedure, except in the case where prior arrangements have been approved by Schwartz Laser Eye Center for insurance billing or financing. I understand that I am financially responsible for all services rendered at Schwartz Laser Eye Center. Please note, we do NOT accept personal checks on the day of your procedure, nor do we accept them within 10 days prior to the procedure date. A $25 charge will apply to all returned checks.

PATIENT SIGNATURE _____ DATE _____