Schwartz Laser Eye Center

PATIENT INFORMATION

Please Print Clearly ***FILL IN ALL BLANK AREAS***

Date_____

Name Mr. Mrs. Ms. Miss _____ _____ _____
Last First Middle Initial

Date of Birth _____ Age _____ Male / Female Referred by:_____

_____ _____ _____ _____
Current Street Address City State/Prov PC/Zip Code

Telephone/Home ( ) _____ E-Mail _____

Telephone/Cell ( ) _____ Work Telephone _____

Employer_____ Occupation_____

Name of Person to contact in case of emergency _____

Daytime telephone ( ) _____ Relationship_____

In addition to contacting me by phone or automated dialing system, I authorize Schwartz Laser Eye Center to contact me via:
E-Mail_____ Text_____ All_____

I authorize Schwartz Laser Eye Center to share my medical information wih the following person(s).

Name:_____ Relationship_____Phone#_____

Patient Signature:_____ Witness Signature:_____Date_____

INSURANCE INFORMATION (Required Information)

Insurance Provider _____ Provider Phone # ( ) _____

Address Claims submitted to _____ City _____ State ____ Zip _____

SS # _____ Marital Status _____ Spouses Name _____

Primary SS#_____ Primary Birthdate_____ Primary Cardholder_____

OCULAR HISTORY

Eye medications presently taking: _____

Do you currently use artificial tears? Y / N If yes, what type and how often?_____

How old are your current glasses? _____ Years/Mos How often has your prescription changed? _____

Do you currently wear contact lenses? Y / N If yes, what type? ____Soft Daily ____Soft Toric ____Soft Extended

How long have you worn contact lenses _____ Yrs/Mos ____Hard/Gas Permeable ____ Monovision?

If Extended wear contacts, how often do you remove them? _____ Clean them? _____

When was your last eye examination? _____ Where? _____

Do you have any of the following or a history of the following? (Please answer all)

Iritis	Y / N	Retinal tear/detachment	Y / N	SPECIFY ANY OTHER EYE ISSUES:_____
Eye Injury	Y / N	Lazy / Crossed Eye	Y / N	
Cataract	Y / N	Keratoconus	Y / N	_____
Glaucoma	Y / N	Family history of Glaucoma	Y / N	
Dry Eyes	Y / N	Macular Degeneration	Y / N	Family History of Macular Degeneration Y / N

Do you have a history of any eye surgeries? Y / N If yes, please specify _____

PLEASE SEE OTHER SIDE

MEDICAL HISTORY

PLEASE FILL IN ALL BLANK AREAS

Primary Care Physician Name: _____ Practice Name: _____

Doctors Address:_____Phone #_____

Pharmacy Name:_____ Pharmacy Phone #:_____

Allergies to medications: _____

Medications presently taking: _____

Do you have a history of any general medical surgeries? Y / N If yes, please specify _____

_____

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

High Blood Pressure	**Y / N**	Shortness of Breath	**Y / N**	Chest Pain	**Y / N**
Heart Attack	**Y / N**	Irregular Heartbeat	**Y / N**	Seizures	**Y / N**
Asthma	**Y / N**	Emphysema	**Y / N**	Bronchitis	**Y / N**
Pacemaker	**Y / N**	Diabetes	**Y / N**	Thyroid	**Y / N**
Arthritis	**Y / N**	Bladder/Kidney	**Y / N**	Lupus	**Y / N**
Chronic Cough	**Y / N**	Tuberculosis	**Y / N**	Hearing Loss	**Y / N**
Abdominal Pain	**Y / N**	Sinus Problems	**Y / N**	Fatigue	**Y / N**
Chrons Disease	**Y / N**	Hepatitis A	**Y / N**	Hepatitis B	**Y / N**
Hepatitis C	**Y / N**	STD	**Y / N**	HIV Positive	**Y / N**
AIDS	**Y / N**	Smoke Y / N		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 surgery and will be discussed with you at the eye exam.

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 fee for the Determination of Refractive State in order to 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 _____