

Registration Form

Acct # _____

Patient Information as of _____ (Please Print Legibly & Fill In All Fields)

Name _____ Birthdate: _____ Age: _____
First M.I. LastAddress _____
Street & Apt # City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone _____ Ext _____

E-mail _____ Contact preference: email? Yes Text? YesGender: Female Male Marital Status S M W D Social Security #: _____ - -

Employer _____ Occupation _____

Address _____
Street & Suite # City State Zip

Emergency Contact Name _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

- How did you learn about our practice? Referral by patient Referral by doctor Radio Station _____ AM/FM
 TV Station _____ Newspaper Ad Internet Site _____ Yellow Pages Other _____

- If through advertising, what was most appealing about the ad? _____

- If referred by a previous patient or a doctor, whom? _____

- How long have you been considering laser vision correction? _____

- What was the primary reason for delaying your decision to proceed, if any? _____

- Have you heard of Blade free IntraLASIK®? Yes No

- Did you consult with any friends or family who've had laser vision correction, prior to this visit? Yes No

- Did you visit our website www.ProvidenceEye.com prior to this visit? Yes No

If yes, how did you learn about it? _____

- Have you visited or considered other vision correction providers? Yes No How many others? _____

- What doctor and/or practice has performed your eye exams in the past 5 years? _____

- When was your last eye exam? _____

Please be aware that because we are dedicating the doctor's time to you personally for this appointment, we require a 48 hour cancellation notice if you need to reschedule your appointment. A \$50 cancellation or no show fee will be assessed otherwise. Because our practice is based on providing the utmost personal attention, we hope that you understand that this policy is necessary in order for us to continue to provide quality care to all of our patients.

I understand that office visit charges are payable on the day service is rendered. Initial IntraLASIK evaluations are complimentary only if there is no previous history of eye surgery. They also do not necessarily substitute for a complete eye exam, and any additional service such as a prescription for glasses or management of any eye problem determined during the initial evaluation is considered a billable service. I authorize Providence Eye & Laser Specialists (PELS) to bill my insurance company for such services (if the practice participates with my plan). Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that PELS does not accept any insurance allowances for laser vision correction, referred to by insurance companies as CPT code #66999, which is typically considered a non-covered procedure. My contract is between Providence Eye & Laser Specialists, P.C. and myself. Please provide our office with your insurance cards and your drivers license so that we can scan them into our system.

Signature _____

Date _____

EYE HISTORY

• Please circle any of the following symptoms you may have with night vision.

Blurred vision Halos Glare Ghosting

• How old is the prescription in your glasses? _____

• Do you wear contact lenses? Yes No • Do you sleep in your contact lenses? Yes, No
What type of lenses? _____

• How long have you been wearing contacts? _____

• When did you discontinue contact lens wear? _____

• Have you been treated for Dry Eye? Yes No

• Have you ever had any surgery, injuries or laser treatments to the eye? Yes No
If yes, please list: _____

• Are you currently corrected for or interested in Monovision? Yes No Do not know

• Do you or have you ever been treated for the following: (Check all that apply)

- Collagen, vascular, autoimmune, or immunodeficiency disease (e.g., Arthritis, Lupus or HIV)
- Signs of keratoconus (a corneal disease) or have any other condition that causes thinning of your cornea
- Corneal erosions or abrasions
- Glaucoma
- Lazy eye or wandering eye
- Herpes eye infections
- Taking Accutane for acne or Cordarone for controlling normal heart rhythm
- Presently** pregnant or nursing
- Double vision (seeing two of the same image side by side or up and down)

• Is there any immediate family history of any of the following?

- Cataracts Glaucoma Strabismus (lazy eye) Retinal disease Cornea transplant Blindness

MEDICAL HISTORY

Primary Care Physician: _____ Practice Name: _____

Do you have or have you ever been treated for the following: (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Keloids | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Brain or nerve disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Bypass Surgery |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Other Heart Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Digestive Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Other Lung Disorders | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> HIV/ AIDS | |
| <input type="checkbox"/> Nephritis | <input type="checkbox"/> Cancer or tumor, Type: _____ | |
| <input type="checkbox"/> Diabetes, If so, how long? _____ | Are you presently using insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

List all medications that you are ALLERGIC to: _____

List all medications and dosages, including eye drops, that you are CURRENTLY taking, including those over the counter. Also include ANY recent vaccinations.

List all surgeries you have had: _____
