Toledo LASIK & Cataract

PATIENT INFORMATION Today's Date ___/___/___

***In the event that we may need to contact you either at home or at work, please complete the following information. If you are unable to receive correspondence at your place of employment please indicate by checking this box.*** ☐

**First Name**_____ **Last Name** _____

**Date of Birth** _____/_____/_____ **Marital Status – M S D W**

**Home Address**_____

**City**_____ **ST**_____ **Zip**_____

**Home Phone**_____ **Cell Phone**_____

**Employer Name**_____

**Work Address**_____

**City** _____ **ST**_____ **Zip**_____

**Work Phone**_____

**E-mail Address (if available)** _____

**Your Optometrist or Ophthalmologist** _____

**1) Have you taken any of the following medications in the past 3 months?**

| | | |
|---|---|---|
| **Prednisone** | **☐ Yes** | **☐ No** |
| **Steroids** | **☐ Yes** | **☐ No** |
| **Acutane** | **☐ Yes** | **☐ No** |
| **Chemotherapy** | **☐ Yes** | **☐ No** |
| **Insulin** | **☐ Yes** | **☐ No** |

**2) Do you have any of the following health problems?**

| | | |
|---|---|---|
| **Rheumatoid arthritis** | **☐ Yes** | **☐ No** |
| **Lupus** | **☐ Yes** | **☐ No** |
| **Diabetes** | **☐ Yes** | **☐ No** |

**3) Are you pregnant or nursing?** **☐ Yes** **☐ No**

**4) Please list any allergies to medication:**_____

**5) Please list current medications you use:**

**6) Please list any medical conditions not indicated in line 2:**

**7) Have you ever had any of the following eye diseases?**

| | | |
|---|---|---|
| **Keratoconus** | **□ Yes** | **□ No** |
| **Herpes keratitis** | **□ Yes** | **□ No** |
| **Glaucoma** | **□ Yes** | **□ No** |

**8) Have you had significant vision or prescription changes in the past 12 months?**

**□ Yes** **□ No**

**9) If you wear contact lenses, please complete the following:**

| | | |
|---|---|---|
| **Soft Lenses** | **_____** | **Last date worn** |
| **Hard Lenses** | **_____** | **Last date worn** |
| **Gas Permeables** | **_____** | **Last date worn** |

**10) Do you wear bifocals?** **□ Yes** **□ No**

**11) Have you had any experience wearing contact lenses for monovision?**

**□ Yes** **□ No**

**12) I am interested in Financing.** **□ Yes** **□ No**

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**To assist us with our marketing, please share with us how you heard about The Toledo LASIK Center.**
**Please Be Specific**

**Insurance**_____
**Direct Mail** _____
**Newspaper**_____
**Radio**_____
**Television**_____
**Billboards**_____
**Internet**_____
**Seminar**_____
**Yellow Pages**_____
**Patient Referral**_____
**Doctor Referral**_____

**Pupils =**

**Thank You!** **Orbscan =**

***For office use only:*** **Pt. is _____ years old.**

OD_____ OS_____

Vc/ Vs/ Allergies:

Dear Patient,

Should you decide to have Lasik Surgery with Dr. Wiley and The Toledo Lasik Center your next step will be a pre-operative examination. The pre-operative examination will take approximately 60-75 minutes. Your eyes will be dilated during this exam. Most patients experience difficulty focusing for near vision after dilation but generally have no difficulty with distance vision. If you've never been dilated you may wish to bring a driver. You will have increased sensitivity to bright light after dilation, please plan to bring sunglasses to this exam. Dilation duration varies from 6 hours to 30 hours depending on your sensitivity to the drops used.

You will also need to have your contact lens off the prescribed amount of time: daily wear soft – two weeks, hard or gas permeable – 6 weeks, extended wear and toric soft – time varies based on your wearing schedule. If you have any questions regarding this time frame please call the office to verify which applies for your individual situation. It is very important that your contacts are off long enough to allow the cornea to return to its natural shape.

Payment in full is due at the pre-op appointment to secure your surgery date and time. We accept all major credit cards, check or cash. If we cancel your surgery because you are not a candidate you will receive a full refund. If you complete your pre-op exam but choose not to have surgery or cancel a scheduled surgery date (other than not being a candidate) $100 will be charged for the pre-op exam or you will receive a refund of all payments less $100 for the pre-op exam.

Once again, congratulations on your decision. If you have any questions regarding this information, please call our office.

_____ _____

Patient Signature Date

_____ _____

Witness Date

# Insurance Coverage Disclosure

While most medical and vision insurances do not offer coverage for LASIK or other elective vision correction procedures, it is possible that you have a benefit which allows for a discount towards these procedures. You may also have coverage that provides for a direct reimbursement to you from your insurance carrier or another third party benefit source.

It is the responsibility of all patients to determine in advance of surgery whether or not they have any insurance benefit or other coverage for LASIK and/or other vision correction procedures. This includes but is not limited to discount programs and direct to patient reimbursement funds or third party billable benefits.

If you are a participant in any of these programs you must inform us prior to your surgery allowing sufficient time to determine what, if any, benefit applies. Please understand that your insurance coverage is a contract between you, your employer and the insurance company. We are not a party to that contract.

Should it be determined that Toledo LASIK Center is a qualified provider under your benefits program, the payment arrangements will need to be discussed in detail prior to your surgery so that all parties will have enough time to make an informed decision about how to proceed with payments and verification of eligibility.

Toledo LASIK Center and its agents are not responsible for determining the level of coverage provided by your insurance carrier and we do not file claims for LASIK surgery (except where it is required for the provider reimbursable component). We will assist you whenever and wherever reasonably possible. Please understand should an insurance benefit or other coverage be determined after surgery has been performed; it may reduce your benefit amount or may eliminate it all together. It may also change your enhancement coverage as well. Toledo LASIK Center and its agents do not offer a refund policy after the date of surgery. _____ (**please initial**).

**Toledo LASIK Center does no insurance billing or acceptance of reimbursement payments from third party insurance companies.**

X_____

We encourage you to ask questions of your insurance carrier, employer's benefits manager and our staff in helping guide you through this process. It is our desire to make your vision correction procedures as stress-free as possible.

Please Print Name:_____

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____