EAU CLAIRE LASIK

REGISTRATION & MEDICAL HISTORY

Patient Information (Please print)

First Name_____ Middle Initial ____ Last Name _____Title _____

Date of Birth _____/_____/_____ Age_____ Sex_____

Address_____City_____State _____ Zip_____

Phone: Mobile _____ Home _____ Work _____

For convenience, many patients choose to receive information about their care via text. Please check here to allow texts: ☐

Email _____Social Media you commonly use _____

Occupation _____ Employer _____

Emergency Contact _____ Phone _____

Friends/Family Members with whom Eau Claire LASIK can discuss my medical care and/or share my medical and/or financial information:

Name_____ Relationship to you _____
Name_____ Relationship to you _____
Name_____ Relationship to you _____

How did you hear about Eau Claire LASIK? (Check all that apply)

☐ Friend/Family Member _____ ☐ Google ☐ Social Media
☐ TV If so, which channel: _____
☐ Newspaper/Magazine ☐ Mailer ☐ Review Site ☐ Other _____
☐ Vision Insurance | Employer providing insurance _____ Vision Plan _____
☐ My Eye Doctor | Name _____

What activities/hobbies do you currently enjoy, or wish you could enjoy more without glasses or contacts?

_____

How long have you been considering having your vision corrected/improved? _____

If you are a candidate for Eau Claire LASIK vision correction, how soon would you like to have treatment?

_____

How do you plan to pay for LASIK?

☐ Financing ☐ Cash/Check/Credit Card ☐ FSA/HSA ☐ Other _____

What questions can we make sure your Eau Claire LASIK Medical Team answer for you while you're with us today?

☐ Why does Eau Claire LASIK use all-laser technology?

☐ How much experience does the surgeon have with Eau Claire LASIK?

☐ Which technology will be the safest option for my eyes?

☐ What differentiates Eau Claire LASIK from other LASIK providers?

☐ Other _____

VISION HISTORY

Eye Doctor Name _____ Practice/Location _____ Date of Last Eye Exam_____

Do you regularly use a specialized driver's license? ☐ CDL ☐ Pilot ☐ Motorcycle ☐ Other _____

How well do you see with your glasses or contact lenses? ☐ Very Well ☐ Okay ☐ Not Well, if not, did you ever? ☐ Y ☐ N

Have you had another LASIK exam and been deemed a candidate? ☐ Yes ☐ No

If Yes, where was your exam? _____ How long ago was it performed? _____

How do you correct your vision?

☐ Glasses: How old are your current glasses? _____Do your glasses have prism? ☐ Y ☐ N ☐ I don't know

☐ Contacts: What Type? ☐ Soft ☐ RGP/Hard ☐ Toric/Astigmatism | Do you sleep in your contacts? ☐ Yes ☐ No How many years have you worn contacts? _____When did you last wear your contacts? (Date) _____ Have you ever been diagnosed with or treated for:

☐ Amblyopia (lazy eye) ☐ Flashes or Floaters ☐ Iritis ☐ Strabismus (crossed eyes)

☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Keratoconus (including immediate family)

☐ Corneal Disease ☐ Herpes of the Eye ☐ Retinal Detachment ☐ Stye or Chalazion

☐ Diabetic Retinal Disease ☐ Infection of Eye or Lid ☐ Retinal Disease ☐ None of the above

If you checked any of the above, please describe _____

Have you ever had any surgery, injury, or laser treatments to the eye? ☐ Yes ☐ No

If yes, please describe _____ How often do you rub your eyes? _____

Do you think you have any signs or symptoms of dry eyes? ☐ Yes ☐ No If yes, please describe _____

_____

MEDICAL HISTORY

List all medications that you are ALLERGIC to: ☐ None

_____

Are you allergic to LATEX? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No Are you Nursing? ☐ Yes ☐ No

List all medications you currently take (including eye drops) ☐ None

_____

List all major injuries, surgeries, conditions and or/illnesses you have/had (Diabetes, Hypertension, Rheumatoid Arthritis, Sjogren's, HIV/AIDS, Hepatitis, etc.) ☐ None

_____

Have you ever been or are you now being treated for MRSA or any other infection that was not controlled by antibiotics in a single cycle? ☐ Yes ☐ No If yes, what type of infection?

_____

LASIK Consultation

I understand that this evaluation is to determine if I am a candidate for laser vision correction treatment (LASIK or PRK) only. It is not a substitute for a routine eye examination.

Authorization to Release Medical Records

By signing below, I hereby authorize ECL to send my medical records to the ophthalmologist or optometrist of my choice for continuity of care purposes, and the ophthalmologist or optometrist of my choice to receive my medical records for continuity of care purposes. This authorization will expire one (1) year from the date of my signature or upon my written request to cancel this authorization. I understand that I may cancel this authorization at any time by submitting a written request to Eau Claire LASIK 1720 Harding Ave. Eau Claire WI 54701. I understand that my cancellation will not apply to any disclosures made by ECL prior to receiving my notice of cancellation.

HIPAA Notice of Privacy Practices

By signing below, I acknowledge that I have read and understand the HIPAA Notice of Privacy Practices which describes the ways in which ECL may use or disclose my protected health information and also describes my rights regarding any such use or disclosure. I understand that I may contact ECL Privacy Officer via mail (1720 Harding Ave., Eau Claire, WI 54701) or via email (support@eauclairelasik.com) if I have any questions.

Patients Rights and Responsibilities

By signing below, I acknowledge that I have read and understand my Patient Rights and Responsibilities Document which describes my rights and responsibilities as a patient. At ECL we strive to ensure that your rights are met. If you have any questions regarding this information, please discuss your concerns with a ECL staff member.

Advertising Consent

I hereby agree, consent, and grant to Eau Claire LASIK, 1720 Harding Ave, Eau Claire, WI 54701 the right and permission to use, re-use, publish, re-publish, display, perform, transmit, exhibit, and reproduce my name, statements, voice, video, photograph, or other likeness, in whole or in part, individually or in conjunction with other material, in any medium (including, without limitation, the ECL website, Facebook page, Instagram page, and other social media properties) for any and all purposes related to marketing, advertising, publicity and promotion, without restriction as to manner, frequency or duration of usage, and without any compensation to me. If you wish to opt out, check here: ☐

Patient Signature _____ Date_____