EYE CARE
OF DELAWARE LLC

Welcome to Eye Care of Delaware and thank you for scheduling an appointment to determine if you are a candidate for vision correction surgery. We look forward to meeting you on:

Dr. Jeffrey Boyd, a board-certified ophthalmologist, performs LASIK, CustomVue LASIK, Refractive Lens Exchange, and implants the Visian Implantable Collamer Lens (ICL) to help patients free themselves from dependency on glasses or contact lenses. We are also the first practice in Delaware to implant the Kamra™ inlay to free patients from the everyday frustrations of wearing reading glasses.

During your complimentary screening our team will check your vision, perform a few simple tests, and take the time to explain all available options to improve your vision since you may be a candidate for more than one type of surgery.

You should plan to spend approximately one hour at our office to complete this screening. It is not necessary to discontinue wearing your contact lenses for your screening appointment.

To expedite your registration, please bring the following with you:

- Enclosed forms (completed)
- Current eyeglasses

If you would like to learn more about Dr. Boyd and options in vision correction surgery, please visit our website at eyecareofdelaware.com and click on vision correction or Kamra. We look forward to meeting you and hope that we can help you see things differently!

Sincerely,

Refractive Surgical Team

Enclosures

4102 Ogletown-Stanton Road, Suite 1 • Newark, Delaware 19713-4183 • (302) 454-8800 • Fax (302) 454-8801 • eyecareofdelaware.com

Eye Care of Delaware Patient Health Questionnaire

Name: ______________________________ Date of birth: ______________

Referred by: ______________ Eye doctor: ______________ Family doctor: ______________

Pharmacy name: ______________________________ Phone #: ______________

Pharmacy location: ______________________________

Reason for today's visit (signs/symptoms): ______________________________

____

______________________________ When did this start? ______________

Location: ☐ Right Eye ☐ Left Eye ☐ Both Eyes   Date of last eye exam: ______________

Severity: Mild   Moderate   Severe   Quality (blurry, foggy, double): ______________

Do you have difficulty with any of these activities, even with your glasses? (circle all that apply):

driving   reading   writing/paying bills   watching tv   computer use   crafts   recreational activities   other

Do you use any eye drops?: ☐ yes ☐ no   If yes, list: ______________

Do you wear glasses? ☐ yes ☐ no   Do you wear contact lenses ? ☐ yes ☐ no

If you wear contact lenses, date last worn? ____________________ (circle one) Soft Lenses   Hard Lenses

Have you had any prior eye surgery? ☐ yes ☐ no   Explain: ______________

List any other surgeries with approximate dates: ______________

____

____

Have you ever been **diagnosed** or **treated** for any of the following conditions?

Cataracts	yes	no	Corneal Disease	yes	no	Dry Eyes	yes	no
Glaucoma	yes	no	Macular Degeneration	yes	no	Eye Trauma	yes	no
Iritis	yes	no	Retinal Disease	yes	no	Crossed or Lazy Eye	yes	no

Do you have a **family** history of any of the following?

Cataracts	yes	no	Macular Degeneration	yes	no	High Blood Pressure	yes	no
Glaucoma	yes	no	Diabetic Retinopathy	yes	no	Corneal Disease	yes	no
Diabetes	yes	no	Retinal Detachment	yes	no	Other hereditary? ______		

Occupation: ______________ Hobbies: ______________

Circle one: Married   Single   Divorced   Widowed

Circle one: Live alone   Live with family or friends   Assisted Living

Do you drive? yes no

Do you drink alcohol? yes no   If yes: Occasionally   1/day   2-3/day   4+/day

Do you use tobacco? yes no   If yes: Occasionally   1/2 pack/day   1 pack/day   1+ pack/day

Do you use recreational drugs? yes no   Have you ever had a blood transfusion? yes no

Famales: Are you pregnant: yes no

Your eyes may be dilated for your exam. Dilation will make the pupils of your eyes large for several hours and cause light sensitivity, glare, and blurred vision. Dark sunglasses are required. If you do not have your own sunglasses, please ask us for a pair. We recommend you have someone drive you home from a dilated exam. A driver is required if you are having a surgical procedure. ______________________________

By signing the other side of this form I am attesting that the information provided is true and accurate. Any ommissions or incorrect information may affect my treatment.

DATE FORM WAS COMPLETED:______________

****** Patients, please complete and sign the other side of this form. ******

Patient Medical History for: ______________________________________(print name)

Have you had any medical problems in any of the following areas? Please check and explain.

I have no medical conditions. Initial here _______

Constitutional	Y	Explain
Weight loss		
Trouble sleeping		
Other		

Eyes	Y	Explain
Vision loss		
Any changes in vision		
Eye pain		
Other		

Ears, Nose, Mouth, Throat	Y	Explain
Hearing loss		
Sinus problem		
Infections		
Other		

Cardiovascular	Y	Explain
Heart attack		
High blood pressure		
Last blood pressure:		
Heart murmur		
Irregular heart beat		
Mitral valve prolapsed		
Chest pain		
Circulation problems		
Other		

Respiratory	Y	Explain
Asthma		
Bronchitis		
Shortness of breath		
Emphysema		
Tuberculosis		
Other		

Endocrine System	Y	Explain
Thyroid condition		
Other		

Diabetes	Y	Explain
Are you diabetic?		
When diagnosed?		
On insulin?		times per day?
Hgb A1c?		
Recent range:	From:	To:
Do you test at home?		
On kidney dialysis?		
Other		

Musculoskeletal	Y	Explain
Osteoporosis		
Arthritis		
Muscle pain		
Other		

Integumentary	Y	Explain
Keloid scarring		
Rashes, sensitivities		
Skin cancer		
Breast cancer		
Other		

Allergic or Immunologic	Y	Explain
Lupus		
HIV		
Other		

Psychiatric	Y	Explain
Depression		
Psychosis		
Mania, biopolar		
Schizophrenia		
Other		

Neurological	Y	Explain
Seizure		
Stroke		
Paralysis/weakness		
Numbness		
Migraines		
Other		

Blood	Y	Explain
Anemia (low count)		
Excessive bleeding		
Bruising easily		
Clotting problems		
Other		

Gastrointestinal	Y	Explain
Ulcers		
Diverticulitis		
Constipation		
Hepatitis		
Other		

Genitourinary	Y	Explain
Kidney infections		
Urinary infections		
Prostate cancer		
Other		

Signature:

Date: ____________________

Patient Name: Date of Birth:

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Medications: List all medications you take including prescribed, over the counter, herbal supplements and vitamins. Be sure to include any eye drops that you use. List <u>medication</u> allergies below.

Medication	**Dosage**	**Frequency**	**To the right of this shaded area is for technician use only.**								
Physician's Signature											

Note: If medication is **<u>not</u>** taken orally, please inform the technician at the time of your office visit.

Are you allergic to any medications?: Yes No

List medication allergies: ______________________________

____

Do you use tobacco? Yes No If yes, ___________ packs / cigarettes per day. Counseled: ________________

Patient Name:____

PRIVACY AUTHORIZATION NOTICE

I have read the Notice of Privacy Practices and by signing this form consent to the use and disclosure of my protected health information. I have the right to review the Notice before signing this consent and I am aware that terms of the Notice may change. I authorize you to leave personal health information on my answering or voice mail system and we will utilize all phone numbers provided, including cellular phones. Telephone calls may include computerized reminder calls. Additionally, I authorize the release of information to the following person(s):

Name	Relationship
____	_________________________________
____	_________________________________

PATIENT CONSENT FOR MEDICAL RECORDS MAINTENANCE

I have read the Eye Care of Delaware, LLC Medical Records Maintenance Policy (included in the Notice of Privacy Practices) and by signing this form consent to this arrangement.

EYE CARE OF DELAWARE, LLC OFFICE POLICY

I have read the Eye Care of Delaware, LLC/Cataract and Laser Center, LLC Office and Financial Policy and by signing this form consent to the terms.

Signature: ____ Date: _______________

PATIENT AUTHORIZATION ASSIGNMENT OF MEDICARE/MEDICAID BENEFITS

I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to any physician utilizing the Eye Care of Delaware and/or Cataract and Laser Center for any service furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Service (CMS) and its agents any information needed to determine these benefits payable for related services. In Medicare/Medicaid assigned cases, the provider agrees to accept the charge determination of the Medicare/Medicaid carrier and I am responsible for the deductible, co-insurance and/or the 20% Medicare does not pay, and for any non-covered services. My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

Signature: ____ Date: _______________

COMMERCIAL/HMO/BLUE SHIELD/SECONDARY INSURANCE

I request that the payment of authorized benefits be made either by me or on my behalf to any physician utilizing the Eye Care of Delaware and/or Cataract and Laser Center, for services provided to me. I authorize any holder of medical information about me to release it to my insurer, or any information needed to determine these benefits payable for related services. I am responsible for any insurance deductible, co-insurance, non-covered services and exclusion of benefits. It is my responsibility to obtain any referrals required for services. If a referral was required and not obtained I will be responsible to pay for the services received. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered valid as the original.

Signature: ____ Date: _______________