



DLC CONSULTATION FORM

PATIENT DATA

Last Name: _____ First Name: _____ Sex: M F

Date of Birth: _____ Age: _____ Telephone: Home (_____) _____

Address: _____ Business (_____) _____

City: _____ State: _____ Zip/Postal Code: _____

SS#: _____ Employer: _____ Occupation: _____

Healthcare Provider: _____ Vision Coverage: No Yes _____

Emergency Contact Name _____ Phone _____ Relationship _____

Past Ocular History: None

- | | | |
|---|---|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinal Tear/Detachment |
| <input type="checkbox"/> Keratoconus | <input type="checkbox"/> Strabismus | <input type="checkbox"/> Herpes Simplex/Zoster |
| <input type="checkbox"/> Amblyopia/Lazy Eye | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Trauma/Foreign Body/Scar |
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Corneal Abrasion | <input type="checkbox"/> Recurrent Erosion |

Past Ocular Surgery: None

- | | | |
|---|--------------------------------------|------------------------------------|
| <input type="checkbox"/> PRK | <input type="checkbox"/> Muscle | <input type="checkbox"/> Retinal |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> RK/AK | <input type="checkbox"/> LASIK/ALK |
| <input type="checkbox"/> Corneal Transplant | <input type="checkbox"/> Other _____ | |

Contact Lens History: None

How long have you been out of your contacts? _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Soft Toric | <input type="checkbox"/> Soft Daily Wear | <input type="checkbox"/> Soft Overnight Wear |
| <input type="checkbox"/> Rigid Gas Perm (RGP) | <input type="checkbox"/> Hard Contacts (PMMA) | <input type="checkbox"/> # of Years _____ |

Medication Allergies: None

List: _____

Medications: None

List: _____

General Health Problems: None

Arthritis:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pregnant/Breast Feeding:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Healing Problems/Keloid:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Claustrophobia:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lupus:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other: _____					

Do you have a "long term" eye doctor? (i.e. a doctor you plan on seeing again)

No, I have seen different doctors in the past. Yes, Dr: _____ **Last Exam:** _____

I was referred to Dell Laser Consultants by:

My eye doctor: _____ My friend/family: _____
 Radio: _____ Newspaper: _____
 Other: _____

Consent to Treat

I have requested medical services from Dell Laser Consultants on behalf of myself. I agree to and understand that my eyes may be dilated in order for the doctor to thoroughly check the retina of the eye. I understand that if my pupils are dilated, I may not be able to safely operate a motor vehicle and that the staff and doctors of Dell Laser Consultants request that I arrange alternate transportation.

Assignment of Benefits

I understand I am fully financially responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), Medicare, private insurance and any other health/medical plan, to issue payment check(s) to Dell Laser Consultants for medical services rendered to myself regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Dell Laser Consultants to: (1) release any information necessary to insurance carriers regarding my treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Patient Signature

Date

Witness

Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Name of Patient

Signature of Patient

Date