DLC
DELL LASER CONSULTANT

DLC CONSULTATION FORM

PATIENT DATA

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

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

Address: _____ Business (_____)_____

City: _____ State: _____ Zip/Postal Code: _____ E-mail address: _____

SS#: _____ Employer: _____ Occupation: _____

Healthcare Provider: _____ LASIK Vision Coverage: □No □Yes _____

Emergency Contact Name_____ Phone_____ Relationship_____

Past Ocular History: □ None

□ Dry Eyes
□ Trauma/Foreign Body/Scar
□ Herpes Simplex/Zoster eye infection
□ Retinal Tear/Detachment
□ Glaucoma
□ Keratoconus
□ Cataracts
□ Corneal Abrasion
□ **Family** History of Cornea Transplant
□ **Family** History of Keratoconus
□ Strabismus
□ Double Vision
□ Amblyopia/Lazy Eye

Past Ocular Surgery: □ None

□ PRK
□ LASIK/ALK
□ RK/AK
□ Corneal Transplant
□ Cataract
□ Other _____
□ Retinal
□ Muscle

Contact Lens History: □ None or # of Years _____

How long have you been out of your contacts?_____

□ Soft Toric
□ Rigid Gas Perm (RGP)
□ Soft Daily Wear
□ Hard Contacts (PMMA)
□ Soft Overnight Wear

Medication Allergies: □ None List: _____

Medications: □ None List: _____

_____

_____

General Health Problems: □ None

Arthritis:	□ Yes	□ No	Asthma:	□ Yes	□ No
Diabetes:	□ Yes	□ No	Pregnant/Breast Feeding:	□ Yes	□ No
High Blood Pressure:	□ Yes	□ No	Healing Problems/Keloid:	□ Yes	□ No
Claustrophobia:	□ Yes	□ No	HIV:	□ Yes	□ No
Anxiety	□ Yes	□ No	Lupus:	□ Yes	□ No
Depression	□ Yes	□ No	Pacemaker:	□ Yes	□ 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