Yaldo Eye Center
THE VISION EXPERTS

Advanced Vision Correction Pre-Evaluation Questionnaire

Patient Name: _____

Your Occupation: _____ **Your Age:** _____

How did you hear about us: _____

Please tell us a little about yourself…

1. How long have you worn eyeglasses and/or contact lenses? _____ Years.

2. I normally wear (check one): ☐ Eyeglasses ☐ Contact lenses

3. Have you worn contact lenses then quit wearing them? ☐ Yes ☐ No
If yes, what factors caused you to quit wearing contact lenses? _____

_____

4. Why are you interested in advanced vision correction? _____

_____

5. What kinds of close work would you like to do without eyeglasses or contact lenses?

_____

6. What activities do you want to participate in without eyeglasses or contact lenses? _____

_____

7. Do you frequently use a computer monitor or video terminal? ☐ Yes ☐ No

8. Have you had friends, family or co-workers who have had vision correction? ☐ Yes ☐ No
If yes, what relationship are they to you? _____

9. What questions or concerns do you have about Advanced Vision Correction?

_____

10. On a scale of 1 – 10, how interested are you in having your vision corrected?
(1=not interested, 5=interested, but need more information, 10=ready to have clear vision today)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

11. Since Advanced Vision Correction is not normally covered by insurance, how do you plan to pay for the procedure? ☐ Cash or check ☐ Credit card ☐ Financing

12. How soon do you want to have your vision corrected?
☐ As soon as possible ☐ In 1 to 3 months ☐ In 3 to 6 months ☐ In 6 months plus

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Patient Registration Form

Patient Name		Cell Phone*		Alternate Phone*
E-mail		Occupation or Previous Occupation		
Address		City	State	Zip Code
Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Widowed	Social Security Number		Date of Birth

Insurance Information

Primary Medical Insurance
Subscriber Name: _____ Group Number: _____

Policy Number: _____ Subscriber DOB : _____

Secondary Medical Insurance (if any)
Subscriber Name: _____ Subscriber DOB _____

Policy Number: _____ Group Number: _____

Vision Insurance (if any)

Subscriber Name: _____ Policy Number: _____

Emergency Contact Information:

Name: _____ Phone: _____

Authorization: I hereby authorize the release of any medical information necessary to process my insurance. I also hereby authorize payment directly to the provider of services. I understand that I am financially responsible for charges not covered by this authorization.

Acknowledgement: I acknowledge that interest may be charged on all accounts that are 90 days or more past due at a rate of 1½% per month, annual rate 18%. I understand that interest charges will be added to any account I have that is 90 days or more past due and hereby agree to pay such charges if levied.
* I agree that Yaldo Eye Center is authorized to reach me at any phone number provided and may leave a message if I am not available. I may also be contacted by e-mail.

Please initial here to acknowledge you have received our _____ (initial)

Office's Notice of Privacy Form (HIPPA Form) _____ (witness)

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Medical Health History Form

Have you had any injury to your eyes? _____ ☐ Yes ☐ No
Have you had a lazy eye? ☐ Yes ☐ No
Have you had a detached retina? ☐ Yes ☐ No
Have you had any prior eye surgeries? ☐ Yes ☐ No
If yes, what kind? _____
Has a family member had glaucoma? ☐ Yes ☐ No
If yes, who? _____
Has a family member had a detached retina? ☐ Yes ☐ No
If yes, who? _____
Have you had any prior surgeries? (Not eye related) _____

PAST MEDICAL HISTORY

Do you now or have you ever had:

☐	Diabetes	☐	HEART PROBLEMS	☐	Crohn's disease
☐	High Blood Pressure	☐	HEART ATTACK	☐	Ulcerative Colitis
☐	High Cholesterol	☐	HEART MURMUR	☐	Stroke
☐	Thyroid Issues	☐	PULMONARY EMBOLISM	☐	Epilepsy (seizures)
☐	Ulcers	☐	BREATHING PROBLEMS	☐	Kidney Disease
☐	Cancer (type) _____	☐	COPD	☐	Kidney Stones
☐	Weight Loss	☐	EMPHYSEMA	☐	Hepatitis
☐	Psoriasis	☐	ASTHMA	☐	Tuberculosis
☐	Headaches	☐	PROSTATE ISSUES	☐	Cortisone Shots/Cream
☐	Sinus Problems	☐	Eczema	☐	HIV/AIDS
☐	Bleeding Problems	☐	Arthritis	☐	Joint Pain
☐	Depression	☐	Liver Problems	☐	Nervous Problems

Other Medical Conditions: (Please List): _____

List all medications you are taking: _____

_____

Are you allergic to any medication? ☐ Yes ☐ No
If yes, what kind? _____
Do you smoke? If yes, how many pack per day? _____ ☐ Yes ☐ No
Do you drink alcohol? If yes, how often? _____ ☐ Yes ☐ No

Primary Care Doctor (Family Doctor)

Name: _____
City: _____
Phone Number: _____

Pharmacy Information

Name: _____
Address/Location: _____
Phone Number: _____

Patient Signature: _____ **Date:** _____

Print Name: _____