



**\*PATIENT MEDICAL HISTORY FORM\***

LAST NAME: \_\_\_\_\_, FIRST: \_\_\_\_\_ MIDDLE INITIAL: \_\_\_\_\_ GENDER: M \_\_\_ F \_\_\_  
 DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ AGE: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_ E-MAIL: \_\_\_\_\_  
 ST. ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELLULAR: \_\_\_\_\_  
 \*PLEASE LIST YOUR REASON(S) AND YOUR EXPECTATION(S) FOR CONSIDERING LASER VISION CORRECTION.\*

AGE OF CURRENT GLASSES: _____  PRESCRIPTION STABLE LAST YEAR: YES _____ NO _____  WHEN WAS YOUR LAST EYE EXAM? _____ (If uncertain, please give us an approximate time such as '2-3 years' ago)	DO YOU WEAR CONTACT LENSES? YES _____ NO _____  TYPE: SOFT _____, SOFT TORIC _____, OR GAS PERMEABLE _____  CONTACTS LAST WORN: _____ ( DAYS) ( MONTHS) AGO. (Please indicate number of days or months and circle the appropriate box.)
--	--

ALLERGIES TO MEDICATIONS: \_\_\_\_\_  
 MEDICATIONS YOU ARE PRESENTLY TAKING: (Accutane? **y/n** Imitrex? **y/n** Blood Thinners? **y/n** ASA, Coumadin? **y/n**) \_\_\_\_\_  
 EYE MEDICATIONS YOU PRESENTLY TAKING: \_\_\_\_\_  
 PATIENT HISTORY OF EYE DISORDERS: \_\_\_\_\_  
 (Keratoconus? Herpes Simplex Virus in/around the eyes?)  
 FAMILY HISTORY OF EYE DISORDERS: \_\_\_\_\_  
 (Keratoconus, Corneal transplants?)  
 PATIENT HISTORY EYE SURGERIES: (Eye Lids? Blepharoplasty?) \_\_\_\_\_  
 AUTO-IMMUNE DISEASES: (Lupus? Rheumatoid Arthritis?) \_\_\_\_\_

**PLEASE CIRCLE YES (Y) OR NO (N) IF YOU HAVE EXPERIENCED OR MAY CURRENTLY HAVE:**

Bronchitis	<b>Y N</b>	Pacemaker	<b>Y N</b>	High Blood Pressure	<b>Y N</b>	HIV positive/AIDS	<b>Y N</b>
Emphysema	<b>Y N</b>	Diabetes	<b>Y N</b>	Bladder/Kidney	<b>Y N</b>	Hepatitis/Jaundice	<b>Y N</b>
Asthma	<b>Y N</b>	Thyroid	<b>Y N</b>	Convulsions/Seizures	<b>Y N</b>	Heart Attacks	<b>Y N</b>
Arthritis	<b>Y N</b>	Chest Pain	<b>Y N</b>	Shortness of Breath	<b>Y N</b>	Do you Smoke?	<b>Y N</b>

ARE YOU PREGNANT OR CURRENTLY NURSING IN THE LAST 6 MONTHS? **Y N** OTHER: \_\_\_\_\_

I attest that all of the information above is correct to the best of my knowledge. I understand that payment is expected in full on the day of my full pre-operative evaluation (not the Free Screening Exam) if I decide to go forward with the surgery. I understand that I am financially responsible for all services rendered at McMann Eye Institute and its affiliates.

Privacy Notice: We do not disclose, give, sell, or transfer any information about you unless required for law enforcement or otherwise by law. I have been provided an opportunity to read and review the NOTICE OF PRIVACY PRACTICES. I acknowledge that I've been offered to receive a copy per my request (\$0.50) as required by HIPPA regulation.

Patient Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_



### *For LASIK Consultations*

During your LASIK evaluation, Dr. McMann may find other eye conditions (unrelated to the vision correction surgery) that require medical care. The doctor will explain these conditions to you. If you would like McMann Eye Institute to treat these conditions, please fill in the insurance information below so we may be able to file a claim with your insurance carrier.

If you are a Tricare Prime beneficiary, you are entitled to one eye examination per year. Your initial consultation is always completely free and will not be billed to Tricare. If you do decide to go forward with LASIK eye surgery, then you will need to return for a complete pre-operative examination to include dilation and refraction within the week before your scheduled surgery. For this complete pre-operative examination, we will bill Tricare for your yearly eye examination for which you're entitled to. This in no way will increase your personal out of pocket cost for your LASIK eye surgery.

### *Insurance Info*

Primary Insurance: \_\_\_\_\_ / Policy #: \_\_\_\_\_

Subscriber: \_\_\_\_\_ / Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Secondary Insurance: \_\_\_\_\_ / Policy #: \_\_\_\_\_

Subscriber: \_\_\_\_\_ / Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

### **Insurance Authorization if applicable**

I hereby authorize my doctor to furnish information to insurance carriers or government agencies concerning my illness and treatments and I hereby assign to them all payments for medical services rendered to myself or my dependents. **I understand I am responsible for any amount not covered by insurance.**

If I am covered by Medicare, I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature \_\_\_\_\_ Date \_\_\_\_\_