Lake Travis Eye and Laser Center, PA

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In order to update your medical history, please complete the following:

Patient Name: _____DOB: _____ Phone# _____

Address: _____

Reason for today's visit: _____

Any known ocular issues you may have? _____

Are you interested in Refractive surgery (LASIK, Kamra Inlay, Clear Lens Exchange) for yourself? ☐ Yes ☐ No

Primary Care Doctor: _____ Preferred Pharmacy: _____

List all medications and eye drops that you are currently taking, both prescribed and over the counter (name, dose & frequency required): OR attach list.

Name:	**Dosage:**	**Frequency:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any known drug allergies:	**Reaction (hives, rash, swelling, etc.):**
_____	_____
_____	_____
_____	_____

List all surgeries (including eye surgeries) that have occurred since your last visit:

_____

_____

_____

Pneumonia shot: ☐ Yes ☐ No **Flu shot:** ☐ Yes ☐ No **Are you Pregnant?** ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No **Birth Control?** ☐ Yes ☐ No

Do you consume alcohol daily? ☐ None ☐ Less than 1 ☐ 1-2 drinks ☐ 3 or more

Tobacco Use? ☐ Never Smoker ☐ Former Smoker, Quit: _____ ☐ Current Smoker ☐ Cigar Smoker

Use of Recreational and Non- Prescription Drugs? (type & how long) _____

Have you ever been treated for drug or alcohol dependency? _____

Review of Systems: Please indicate if you have ever had the following.

☐ Anxiety	☐ Coronary Artery Disease	☐ HIV/AIDS	☐ Radiation
☐ Arthritis	☐ Depression	☐ Hypercholesterolemia	☐ Seizures
☐ Asthma	☐ Diabetes Type 1/ Type 2	☐ Hyperthyroidism	☐ Stroke
☐ Bone Marrow Transplant	☐ End Stage Renal Disease	☐ Hypothyroidism	☐ Other _____
☐ BPH (Benign prostatic hypertrophy)	☐ GERD	☐ Leukemia	
☐ Breast Cancer	☐ Hearing Loss	☐ Lung Cancer	
☐ Colon Cancer	☐ Hepatitis	☐ Lymphoma	
☐ COPD	☐ Hypertension	☐ Prostate Cancer	

Have you had family history of any of the above diseases? If yes, which family member and which disease?

_____

_____

Any family history of Glaucoma or Macular Degeneration? If yes, which family member and which disease?

_____

_____

Refraction Policy

During your visit, a refraction may be performed to determine your need for glasses or to evaluate if any further visual improvement can be achieved. This is a necessary and essential portion of your eye exam and in some cases, it is the sole reason for the appointment. Refractions can help distinguish problems caused by poor focus (a need for glasses) versus problems caused by eye disease. However, the refraction is considered a NON-COVERED service by most medical insurance companies including Medicare regardless of why the doctor performs the test. Please be aware it is the responsibility of the patient to pay the refraction fee of $50.00 (if the prescription is needed) in addition to your copay. **If this fee is not paid at the time of your visit, then we will charge a $65.00 fee if the claim is submitted and your insurance plan does not cover the refraction fee.**

I have read the above policies and understand my financial responsibility and that the refraction is a non-covered service. I accept full responsibility for the cost of all services and agree to pay any additional fees that are not covered by my insurance contract.

_____ _____

Patient Signature Date

Retinal Screening

A retinal screening is an integral part of a thorough comprehensive eye examination. This allows early detection of pathology such as diseases of the optic nerve, disease of the retina, vascular changes, retinal tumors, etc. This is usually done through a dilated pupil. New technology now allows an image of the retina to be captured through an undilated pupil with the Optos camera. It only takes 1-2 minutes to capture the images which will be available for review during your exam and in the future. Please note that we still ask patients with specific symptoms or diagnoses to dilate, in order to view the retina beyond the 80% captured with the Optos (ie. Diabetic Eye Exam, Macular Degeneration, Glaucoma, Flashes & Floaters, Cataract Pre-Ops).

Please understand that this service is **not covered under insurance** as a screening examination. Our office charges a $40.00 fee at the time of your visit for the Optos Fundus Photography. **If the doctor request this image due to specific diagnosis, then we will bill insurance and not collect the fee at the time of your visit until we receive notice of coverage from your insurance.**

_____ I elect to have the Optos image of my retina for $40.00.

_____ I decline the Optos image and am choosing to be dilated.

_____ I decline both the Optos and dilation. I elect not to have a thorough comprehensive eye examination today.

_____ _____

Patient Signature Date