UNIVERSITY of ROCHESTER MEDICAL CENTER

FLAUM EYE INSTITUTE

PATIENT REGISTRATION FORM

Name:_____Date:_____

Address:_____

City/State:_____County:_____Zipcode:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

E-MAIL ADDRESS:_____

Date of Birth:_____ ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

Occupation:_____ Full Time _____ Part Time _____

Employer:_____

Please tell us your hobbies:_____

How did you hear about us? ☐ Democrat & Chronicle

☐ Radio: Circle WHAM WDVI WCMF WPXY WBZA WRMM WBEE OTHER

☐ Our Website ☐ U of R ☐ Direct Mail ☐ Google Ad ☐ Facebook

☐ Trusted LASIK Surgeons ☐ Employer / Corporate Program: _____

Referring Physician:_____ Referring Eye Doctor:_____

Other:_____

Have you attended our Patient Education Seminar? ☐ No ☐ Yes Date of Seminar:_____

Who is your current eye doctor?_____

Do you wish to have your eye doctor provide any of your postoperative care? No ☐ Yes ☐

Primary Care Physician:_____ Address: _____

Medical Insurance:_____ Policy # _____

Policy Holder's Name:_____ Date of Birth:_____

How long have you worn glasses? _____

Has your prescription been changing regularly? ☐ No ☐ Yes

Are you a contact lens wearer? ☐ No ☐ Yes ☐ Soft ☐ Hard ☐ Gas Permeable ☐ Ext Wear

When did you last wear your contacts? _____

In Case of Emergency Notify: Name: _____Phone:_____

Relationship to Patient:_____

Flaum Eye Institute Refractive Surgery Center Patient Health History

Name: _____ **Date:** _____

Allergies – Foods	☐ Yes	☐ No	– Medications	☐ Yes	☐ No
– Iodine	☐ Yes	☐ No	– Seasonal/Pollens	☐ Yes	☐ No
– Latex	☐ Yes	☐ No	– Skin	☐ Yes	☐ No

If Yes to any of above, please explain:_____

_____

Anxiety/Nervousness	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Herpes Simplex (cold sores)	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Herpes Zoster (shingles)	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Cancer (type: _____)	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Chronic Bronchitis	☐ Yes	☐ No	Lupus Erythematosis	☐ Yes	☐ No
Collagen Vascular Disease	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Contact Lens Wear Problems	☐ Yes	☐ No	Sjogren's Syndrome	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Skin Problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	TB	☐ Yes	☐ No
Dry Eyes *without* Contact Lenses	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Eczema/Psoriasis	☐ Yes	☐ No	For women, are you:		
Family History of Keratoconus	☐ Yes	☐ No	Menopausal/Postmenopausal	☐ Yes	☐ No
Fibromyalgia/Chronic Fatigue	☐ Yes	☐ No	Pregnant/Nursing	☐ Yes	☐ No
Frequent Styes/Pinkeye	☐ Yes	☐ No			
Heart Problems	☐ Yes	☐ No			
Do you smoke?	☐ Yes	☐ No	If yes, # of packs per day _____ for _____ years		

Do you ever have pain in your eyes upon awakening in the morning? ☐ Yes ☐ No

Have you ever had abnormal or unusually slow healing from a skin wound or injury? ☐ Yes ☐ No

Have you ever had problems with fainting when receiving shots or when having blood drawn? ☐ Yes ☐ No

Have you had or are you considering cosmetic eyelid surgery? ☐ Yes ☐ No If yes, when? _____

Medications (prescription or over-the-counter) being taken and dosages:_____

_____

Do you use artificial tears? ☐ Yes ☐ No If yes, how often?_____

Any Previous Eye Injuries? ☐ Yes ☐ No If yes, what type and when:_____

_____

Any Previous Eye Surgery? ☐ Yes ☐ No If yes what type of surgery and when:_____

_____

Has anyone in your family ever been diagnosed with or had: Cataracts, Corneal Transplants, Glaucoma, or Unexplained Poor Vision

☐ Yes ☐ No If yes, who?: _____

_____

Any additional eye or general health information that we should be aware of:_____

_____

********** For Office Use Only**********

Reviewed by: _____ Date: _____

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Patient Symptom Questionnaire

Patient Name:_____ Date:_____

Patient Instructions: Please check the appropriate box to rate your symptoms, if any, that you may be experiencing for each of the following categories of potential eye and vision symptoms.

Symptom	Your Personal Experience				
Light Sensitivity	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Headaches	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Eye Pain Upon Awakening	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Eye Pain During the Day	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Redness	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Dry Eye	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Excessive Tearing	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Burning	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Gritty Feeling	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Glare	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Halos Around Lights	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Blurry Vision with Lenses	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Double Vision	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Ghost Images	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Fluctuations of Vision	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Difficulty with Night Driving	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Variable Vision under:					
Bright Light/Sun	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Normal/Indoor Light	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe
Dim Light/After Dark	☐ None	☐ Mild	☐ Moderate	☐ Marked	☐ Severe

For Office Use Only: ☐ Pre-op ☐ Post-op Reviewed by:_____

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Patient Name:_____ Date:_____

Please tell us how important each of the following factors would be in helping you make the decision to have your refractive surgery performed at the Flaum Eye Institute.

	Circle	**1 = Least Important**								**Most Important = 10**
Cost of Treatment	1	2	3	4	5	6	7	8	9	10
Availability of Financing	1	2	3	4	5	6	7	8	9	10
Technology Being Used	1	2	3	4	5	6	7	8	9	10
Dr. Scott MacRae's Reputation	1	2	3	4	5	6	7	8	9	10
Strong Memorial Hospital's Reputation	1	2	3	4	5	6	7	8	9	10
Safety of Procedure	1	2	3	4	5	6	7	8	9	10
Effectiveness of Procedure	1	2	3	4	5	6	7	8	9	10

What specific questions or concerns do you have for us today?

_____

_____

_____

_____

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Description of Services, Release of Information, Financial Agreement

_____ _____

Beneficiary Name Date of Birth

Description of Non-Covered Services:
I understand that the following services provided by The Flaum Eye Institute Refractive Surgery Service may be considered non-covered services by your health care service plan:

- Refractive Surgical Pre-operative Consultation
- Refractive Surgery for the reduction of myopia, hyperopia, and/or astigmatism and presbyopia.

Accordingly, the undersigned accepts full financial responsibility for all items or services which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health service plan or in the benefit summary the health service plan furnished to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with the Flaum Eye Institute Refractive Surgery Service to obtain necessary health care service plan authorizations.

Description of Covered Services:
The Flaum Eye Institute Refractive Surgery Service contracts with health care plans (e.g. HMO's, PPO's, Medicare) to provide services to patients considered "covered" or medically necessary. Examples of these services include punctual occlusion for the treatment of dry eye, diagnostic testing such as corneal topography and evaluation of patients with cornea related medical diagnosis (e.g. post corneal transplant, corneal disease, surgically induced refractive error). If the services provided to the patient by The Flaum Eye Institute Surgery Service are deemed to be covered by your health insurance, you will be responsible for any applicable co-payments or deductibles as defined by your insurance plan.

The Flaum Eye Institute Refractive Service maintains a list of health care plans in which it contracts. The Flaum Eye Institute Refractive Service has no contract expressed or implied with any plan that does not appear on that list. The undersigned agrees that they are individually obligated to pay the full charges of all services rendered to me by The Flaum Eye Institute Refractive Surgery Service if I belong to a plan that does not appear on the above mentioned list.

Release of Information:
The Flaum Eye Institute Refractive Surgery Service may disclose all or any part of my medical record and or financial ledger to any person or corporation (1) which is or may be liable or under contract to The Flaum Eye Institute Refractive Surgery Service for reimbursement for services rendered and (2) any health care provider for continued patient care. The Flaum Eye Institute Refractive Surgery Service may also disclose on an anonymous basis and information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation.

Financial Agreement:

I agree that in return for the services provided to the patient by The Flaum Eye Institute Refractive Surgery Service, I will pay my account at the time service is rendered or will make financial arrangements for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney fees as established by the court. I understand and agree that if my account is delinquent, I may be charged interest at a legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to the Flaum Eye Institute Refractive Surgery Service. If co-payments or deductibles are designated by my insurance company or health plan, I agree to pay them to The Flaum Eye Institute Refractive Surgery Service. However, it is understood that the undersigned and/or the patient are primarily responsible for payment of my bill.

_____ _____

Signature of Patient or Authorized Party Date

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- ☐ Strong Memorial Hospital
- ☐ Highland Hospital
- ☐ Eastman Dental Center
- ☐ The Highlands of Pittsford
- ☐ The Highlands of Brighton
- ☐ Primary Care Network Practice: _____
- ☐ URMFG _____
- ☐ Other: _____

Patient Name: _____
(Please Print)

DOB: _____

Medical Record #: _____

I have been provided with the URMC/ Strong Health Notice of Privacy Practices.

Patient's Signature: _____ Date: _____

OR

Signature of personal representative: _____ Date: _____

Relationship to patient: _____ Date: _____

If signature not obtained, please indicate reason:

- ☐ Patient Declined
- ☐ Emergency Situation
- ☐ Other _____

Staff Member's Name (please print): _____

Department: _____

Date: _____

(Note: This document must be retained for 6 years in accordance with the HIPAA Privacy Rule)

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Flaum Eye Institute

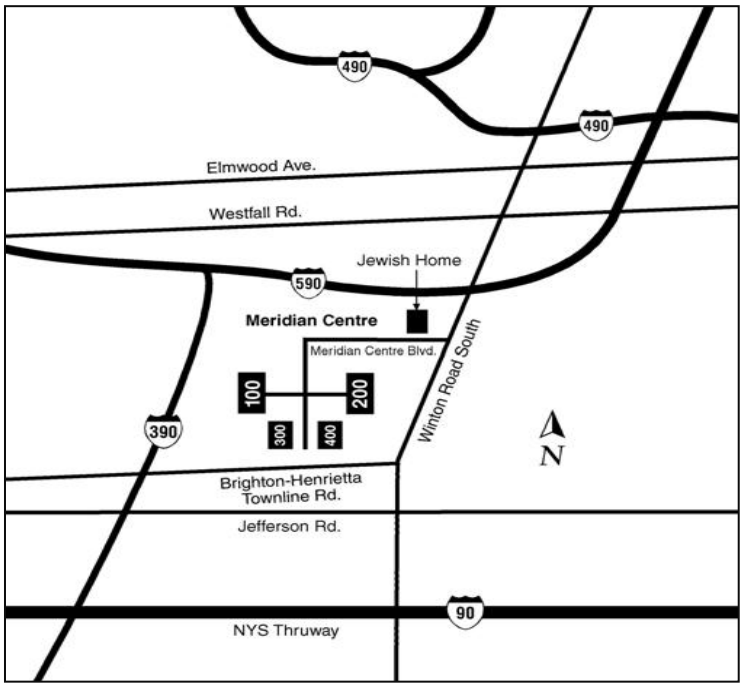
Refractive Surgery Center

LASIK • PRK • Phakic Lens Implant Surgery • Premium IOL Surgery

Scott MacRae, M.D. Ryan Vida, O.D.

100 Meridian Centre, Suite 125 Rochester, NY 14618

Directions to Meridian Centre



From the North

- I-590 South to Winton Road exit
- Turn left off exit at light onto Winton Road
- Once on Winton Road, see below

From the South

- I-390 North to I-590 North to Winton Road exit
- Turn right off exit at light onto Winton Road
- Once on Winton Road, see below

From the East

- I-490 to I-590 South to Winton Road exit
- Turn left off exit at light onto Winton Road
- Once on Winton Road, see below

From the West

- I-490 East to I-390 South to I-590 North to Winton Road exit
- Turn right off exit at light onto Winton Road
- Once on Winton Road, see below

On Winton Road, traveling South

- Pass one intersection at The Jewish Home of Rochester
- Turn right at next light onto Meridian Centre Blvd
- Continue straight to parking entrance on left before end of road

Directions from NYS Thruway / I-90

- Use Exit 46 (Henrietta/Rochester/I-390)
- Follow signs to I-390 North
- Follow “Directions from South” as above

585-273-2020

www.lasik.urmc.edu