HAYDEN VISION

LASIK CHECKLIST

NAME _____ DATE _____

YES	NO	WITHOUT GLASSES OR CONTACT LENSES…
○	○	Do you have trouble seeing at distance?
○	○	Do you have trouble seeing up close?
○	○	Do you have night vision problems? Describe: _____
○	○	Do you have dry eye problems? When: _____
○	○	Are you pregnant or nursing?
○	○	Do you have severe diabetes or severe allergies?
○	○	Do you have any active eye disease such as glaucoma or cataracts?
○	○	Do you have collagen vascular, autoimmune or immunodeficiency diseases (for example: Rheumatoid arthritis, Lupus, AIDS)?
○	○	Do you show signs of keratoconus (corneal disease)?
○	○	Would you be satisfied if your natural vision was greatly improved even if you still had to wear glasses some of the time?
○	○	Do your glasses or contacts interfere with your recreational activities? Which activities: _____
○	○	Do you feel that good vision without glasses is more important to you than perfect vision with glasses?
○	○	Is it acceptable to you that you may need glasses for reading after LASIK?
○	○	Do you have vision problems with reading or computer work?
○	○	Do you have vision issues, limitation, or restrictions with your work or profession? Describe: _____

HAYDEN VISION

REGISTRATION FORM

Today's Date: _____

Name	**Date of Birth**		**Gender**
Address	**City**	**State**	**Zip**
Best Phone Is this: Cell Home Work		**SSN**	
Best Email	**Employer**		
Name of Insured		**Relationship**	
Emergency Contact		**Phone**	
Primary Care Doctor	**Optometrist**		
Pharmacy	**City**	**Phone**	

ASSIGNMENT OF BENEFITS: I request that payment of authorized benefits be made either to me or on my behalf to Hayden Vision for services furnished to me by Hayden Vision providers. I authorize any holder of medical information about me be released to the insurer and its agents as needed to determine benefits payable for related services.

RELEASE OF INFORMATION: Hayden Vision may disclose all or any part of my medical record and/or financial ledger including alcohol or drug abuse, psychiatric illness, communicable disease, or HIV to any person or corporation 1) which is or may be liable or under contract to Hayden Vision for reimbursement of services rendered; 2) any healthcare provider for continued patient care; 3) Family members unless otherwise indicated by the patient. ***DO NOT release medical information to***: _____

FINANCIAL AGREEMENT: I agree that in return for services provided by Hayden Vision, I will pay any amount my insurance does not cover, including deductibles and/or co-payments at the time that services are rendered, or I will make arrangements that day satisfactory to Hayden Vision. If my account is sent to a collection agency, I agree to pay reasonable collection expenses. It is understood that the undersigned and/or patient are primarily responsible for payment of my bill.

SELF PAY PATIENTS: Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Send an itemized receipt with your claim to your insurance carrier who will reimburse you directly.

CO-PAYMENTS: By law we must collect your co-pay at the time of service. Please be prepared to pay this copay at each visit.

NON-COVERED SERVICES: I understand that Hayden Vision contracts with healthcare service plans for services covered by these plans. Accordingly, the undersigned accepts full financial responsibility for all items or services.

REFRACTIONS: A refraction fee of $45.00 is the responsibility of the patient. Insurance considers this a non-medical charge and therefore it is not covered under private insurance, Medicare, or Medicaid benefits.

Signature of Patient or Insured: _____