HAYDEN VISION

VISION PREFERENCES CHECKLIST

NAME _____ DATE _____

The term "cataract" refers to a cloudy lens within the eye. When a cataract is removed, a lens implant is placed inside the eye to replace the cloudy human lens. Occasionally, clear lenses that have not yet developed cataracts are also removed to reduce or eliminate the need for glasses. If it is determined that lens replacement is appropriate, your answers will help us provide the best vision possible so you can enjoy activities most important to you.

❶ If lens replacement is recommended for you, please rate your vision preferences at the following distances?

Distance Vision: driving, golf, tennis, other sports, watching TV.

- ☐ Prefer no distance glasses
- ☐ I wouldn't mind wearing distance glasses

Mid-range Vision: computer, menus, price tags, cooking, board games, items on a shelf.

- ☐ Prefer no mid-range glasses
- ☐ I wouldn't mind wearing mid-range glasses

Near Vision: reading books, newspapers, magazines, doing detailed handwork.

- ☐ Prefer no near glasses
- ☐ I wouldn't mind wearing near glasses

❷ Please check the single statement that best describes you in terms of **night vision:**

- ☐ Night vision is extremely important to me, and I require the best possible quality.
- ☐ I want to be able to drive comfortably at night, but I would tolerate some slight imperfections.
- ☐ Night vision is not important to me.

❸ If you **had to wear glasses after surgery for one activity**, for which activity would you be most willing to use glasses?

- ☐ Distance Vision
- ☐ Mid-Range Vision
- ☐ Near Vision

❹ If you could have good distance vision during the day without glasses, and good near vision for reading without glasses, but the compromise was that you **might see rings or starbursts** around lights at night, would that be OK?

- ☐ Yes
- ☐ No

❺ If you could have good distance vision and mid-range vision during the day and at night without glasses, but the compromise was that you **might need glasses for reading** the finest print at near, would you like that option?

- ☐ Yes
- ☐ No

❻ How many hours per day do you spend:

_____ **On the computer**

_____ **Reading** books, newspapers, typed documents or small print

_____ **Driving**

❼ List your favorite **hobbies or work** activities.

❽ Please place an "X" on the scale to **describe your personality** as best you can:

Easy going — **Perfectionist**

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: _____

HAYDEN VISION

HEALTH HISTORY

New Patient

NAME _____ **TODAY'S DATE** _____

OCULAR HISTORY	YES	NO		YES	NO		YES	NO
Allergic Conjunctivitis			Glaucoma			Retinal Tear		
Blepharitis			Macular Degeneration			Retinal Detachment		
Cataract			Macular Pucker			Strabismus (Lazy Eye)		
Fuchs Corneal Dystrophy			Narrow Angles			Vitreous Detachment		
Diabetic Retinopathy			High Eye Pressure			Other?		
Dry Eyes			Ocular Migraine					

OCULAR SURGERY	R	L		R	L		R	L
Cataract Surgery			Glaucoma Laser			Retinal Tear		
Corneal Transplant			Eyelid Surgery			Retinal Detachment		
Eye Muscle Surgery			Punctal Plugs			Strabismus (Lazy Eye)		
Eye Injections			Strabismus Surgery			Vitreous Detachment		
LASIK			Retinal Laser			Other?		
PRK			Trabeculectomy					

FAMILY HISTORY	YES	NO	FAMILY MEMBER?		YES	NO	FAMILY MEMBER?
Blindness				Retinal Detachment			
Glaucoma				Macular Degeneration			

SOCIAL HISTORY				
Cigarettes	Never	Quit	Occasional	Daily
Alcohol	None	Less than daily	1-2 drinks per day	3+ drinks per day
Occupation				

Please turn page over

MEDICAL HISTORY	
Medications (list here or provide us a list):	Allergies (list or write “none”):
Significant medical conditions? (list)	Significant surgeries? (list)

RECENT CHANGE IN OVERALL HEALTH	**YES**	**NO**		**YES**	**NO**
Fever			Active seasonal allergies		
Uncontrolled blood sugar			Arthritis flare-up		
Chest pain			Depression		
Numbness or burning in feet			Anxiety		
Chemotherapy or radiation treatments			COVID		

How did you hear about our practice? _____