PLEASE TAKE A FEW MINUTES TO PROVIDE THE FOLLOWING INFORMATION. **UDAY DEVGAN, MD, FACS, FRCS**
IT'S ALL IMPORTANT!

Name: _____ Date _____

Home Address _____ City _____ ST _____ ZIP_____

Home Phone (_____) _____ Cell Phone (_____) _____ email: _____

Date of Birth ____-_____-_____ Age _____ Sex ____ SSN _____-_____-_____ Occupation: _____

Employer: _____ Work Phone (_____) _____

Office Address _____ City _____ ST _____ ZIP_____

Emergency Contact: _____ Phone (_____) _____Relation:_____

HOW DID YOU HEAR ABOUT OUR OFFICE?

REFERRED BY: _____ [ ] My Optometrist [ ] A Colleague [ ] A Friend or Relative

[ ] Internet & Web Site [ ] Brochure [ ] Advertisement [ ] Mailer [ ] Newspaper article [ ] Magazine [ ] other: _____

INFO ABOUT YOU AND YOUR VISUAL NEEDS, INTERESTS, HEALTH, LIFESTYLE, ETC.:

FAVORITE ACTIVITIES AND SPORTS: _____

ANY PARTICULAR OR UNIQUE OR UNUSUAL VISUAL NEEDS: [ ] No [ ] Yes_____

How long have you worn correction? _____ Years Do you regularly wear [ ] Glasses [ ] Contacts [ ] both.
Current contacts: [ ] Hard/Gas Perm [ ] Daily Wear Soft [ ] Weekly wear [ ] Monthly Wear Soft [ ] Toric Soft [ ] Multifocal
Any problems with contact lens wear? [ ] Yes [ ] No
If yes: [ ] Dry Eye [ ] Lens/solution allergy [ ] Lens intolerance [ ] Infection or ulcer

Other: _____

Do glasses or contacts limit you in any way? [ ] Yes [ ] No If yes, explain:

_____

MEDICAL QUESTIONS: Do you consider yourself in good health? [ ] Yes [ ] No. If no, explain:
Do you have any of the following conditions: [ ] Rheumatoid Arthritis [ ] Collagen/Vascular disease [ ] Systemic Lupus
[ ] Chronic or recurrent arthritis [ ] Autoimmune disorder No to all [ ]

If yes, explain: _____

_____

Have you ever had eye problems such as: [ ] Iritis or Uveitis [ ] Herpes infection in eye [ ] Keratoconus [ ] Eye injury No [ ]

If yes, explain: _____

Have you had any prior eye surgery? [ ] Yes [ ] No If yes, describe: _____

Do you have any other medical conditions? [ ] Yes [ ] No Explain: _____

Please list all prescription medications you take: _____ _____

_____ _____

Is there anything else about your general health, your eyes, or your vision that you would like us to know?

_____

OUR FREE CONSULTATION CONSISTS OF THE FOLLOWING:

- Measurement of your uncorrected and best-corrected vision.
- Measurement of your current eyeglass prescription.
- Automated measurement of your refraction (best current prescription).
- Measurement of corneal topography, corneal thickness, eye pressure, and other parameters of the eye.
- Measurement of pupil size in darkness.
- Assessment of overall health of the eyes and general medical health.
- Based upon the above information, our staff and Dr. Devgan should be able to advise you about your candidacy for LASIK and/or other methods of vision correction.

In certain circumstances, additional testing, discussion, or time may be necessary to complete our assessment and give you our best recommendations. If this is the case, you will be advised that fees will be incurred for additional consultative services. This may be warranted, for example, if any of the following apply:

If multiple visits are advised for any reason, such as (a) repeat refraction after stopping wear of hard lenses, to determine stability; (b) if treatment of medical conditions of the eyes or eyelids is advised prior to contemplating surgery; etc.

- If extended consultation is required due to individual circumstances or special needs. Examples might include (a) individuals with reduced vision in one eye; (b) if you have had prior laser or other eye surgery;

CONTINUED ON REVERSE SIDE →

- If measurements made as a part of our free consultation warrant extra time, caution, or consideration, as might be appropriate in the case of (a) very high corrections; (b) borderline or thin corneal tissue readings; (c) excessively steep or flat corneal curvature as determined by topographic mapping; (d) small corneal diameter; (e) unusual eyelid configuration, presence of lid disease, or incomplete eyelid closure; (e) very large pupil size; (f) presence of ocular surface disease, significant "dry eye" status, or the like; etc.
- If testing or a several-day trial in soft contact lenses is advised
- If you desire monovision and have not yet tried this type of correction (through use of soft contact lenses), in which case we would recommend an appropriate fitting and trial of such lenses.

After completing the free consultation, if Dr. Devgan and/or staff at LA Sight feel that additional time and or professional services are warranted, you will be so advised. We will inform you of the relevant charges and ask you to sign in the space below indicating your acknowledgement and acceptance of responsibility for this care.

Should you choose to proceed with elective vision correction care at LA Sight, or should you desire medical services above and beyond the scope of vision correction consultation that may be covered by health insurance, we ask that you sign the following statement.

ACCEPTANCE OF TERMS OF PROFESSIONAL SERVICE RELATIONSHIP; FINANCIAL RESPONSIBILITY, AND AUTHORIZATION TO PAY BENEFITS DIRECTLY TO LA SIGHT (IF APPROPRIATE):

I understand I am financially responsible to LA Sight Medical Center and Dr. Uday Devgan for all charges incurred as a consequence of medical care received through this office, including any charges not covered by my insurance carrier.

I hereby authorize the release of any information requested by my insurance carrier concerning my present condition.

I hereby also assign to LA Sight Medical Center all money to which I am entitled for medical and/or surgical expenses relative to the services reported. I permit a copy of this authorization to remain on file and be used in place of an original signature for claims filed. I request that payment of authorized Medicare benefits be made on my behalf to LA SIght Medical Center. Inc. for any services furnished me by or under supervision of it's' physicians. I authorize any holder of medical information about me to release any information needed to determine these benefits and process related claims accordingly.

I further understand that I am entering into a contractual relationship with Dr. Devgan for professional care. I further understand that merit less and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by LA Sight and Dr. Devgan, I and/or my representative agree not to advance, directly or indirectly, any false, merit less, and/or frivolous claim(s) of medical malpractice against LA Sight and Dr. Devgan.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I and/or my representative agree to use ABMS board-certified expert medical witness(es) in the same or similar specialty as Dr. Devgan. Furthermore, I agree that expert witnesses designated by my legal counsel will adhere(s) to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine that would typically have the background and experience to opine on such a case. In further consideration for this, LA Sight agrees to the same stipulations.

_____ _____

Signature Date

HEALTH INSURANCE INFORMATION:

You do not need to fill this out if:
(a) We copy your insurance information card, or
(b) We are not going to be billing your health insurance carrier for any services.

Primary Insurance: _____ Phone _____

Address for Claims _____ City _____ ST _____ ZIP _____

Group No. _____ Policy No: _____ Deductible: _____

Policy Holder _____ ID/SSN _____

Relation to Insured: [ ] Self [ ] Spouse [ ] Child [ ] Other _____