Updegraff Laser Vision

Patient Data Sheet

Patient Information

MR. MS. MRS. MISS (circle one)

First Name_____Last Name_____M_____

Address_____

City _____ State _____ Zip_____

Sex M F Age _____ DOB_____

Hm Ph.#_____Bus Ph.#_____Cell# _____

Employer_____Occupation _____

E-Mail Address _____

Whom may we thank for referring you?_____

Who is your current eye doctor?_____Phone#_____

Has your current eye doctor ever suggested LASIK eye surgery to you? Y N

Emergency Contact Information

Name_____Relationship_____Phone#_____

- How long have you been considering LASIK or another vision correction option?

  _____

- Have you been told in the past that you were a candidate for LASIK and if so, how long ago and by whom?

  _____

- What prompted you to schedule your consultation with our practice?

  _____

  _____

- What activities will you be able to more fully participate in after your vision is corrected?

  _____

  _____

- What is most important to you in making a decision to have your vision surgically corrected?

  _____

  _____

- What is your desired outcome from today's visit?

  _____

  _____

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Assignment and Release

- Refractive procedures are elective and not generally covered by insurance. I understand that unless there is a contractual obligation or prior agreement if you should file my insurance or agree to any alternative form of payment including payment from any third party I am still ultimately responsible for and guarantee the payment of all fees owed.
- During a refractive consultation it may be necessary to dilate my eyes to confirm my candidacy. Dilating drops may blur vision for a length of time that varies from person to person. I authorize Dr. Updegraff and/or his associates to administer dilation drops during any of my consultation visits.
- Should I choose to schedule surgery, I understand that I am responsible for a scheduling deposit today to secure my surgical date.
- In the event that I must cancel my surgical date, I understand that my scheduling deposit is refundable up to 48 hours prior to the scheduled procedure.
- I acknowledge that I have received your Patient Information Privacy Notice.
- I understand this is an initial consultation only to determine my candidacy for a refractive procedure. Unless I follow up with surgery or regular office visits no doctor patient relationship has been established and no information from this consult will be released to anyone.

_____ _____

Patient Signature Date