



1250 Summer Street • Suite 301 • Stamford, Connecticut • 06905
 203) 961-1488 • 888-559-EYES • Fax: (203) 921-1290
 Suresh Mandava, M.D. • Medical Director

Today's Date: _____

PATIENT INFORMATION

First Name: _____ Middle Initial: ____ Last Name: _____
 Nick name or preferred name: _____
 Address: _____
 City: _____ State: ____ Zip: _____ Sex: M F
 E-mail Address: _____
 Home Phone: _____ Cell Phone: _____
 Birthday: ____/____/____
 Are you currently a patient of Greenwich Ophthalmology? Yes No

EMPLOYER INFORMATION

Employer: _____ Occupation: _____
 Address: _____
 City: _____ State: ____ Zip: _____ Telephone: () _____

INSURANCE INFORMATION- Please present your insurance card to the receptionist

Insurance Company Name: _____
 Group #: _____ Policy/Member ID #: _____
 Secondary Insurance Company Name: _____
 Group #: _____ Policy/Member ID #: _____

REFERRAL

Where have you heard about Fairfield County Laser Vision (please check all that apply)?

Please circle the single most important factor that brought you in today.

<input type="checkbox"/> A Doctor _____	<input type="checkbox"/> Magazine _____
<input type="checkbox"/> Friend or Relative _____	<input type="checkbox"/> Attended a Seminar _____
<input type="checkbox"/> Office Personnel _____	<input type="checkbox"/> TV/Radio _____
<input type="checkbox"/> Newspaper _____	<input type="checkbox"/> Brochure in Mail _____
<input type="checkbox"/> Internet _____	<input type="checkbox"/> Other _____

LIFESTYLE

Hobbies/Sports: _____
 Why do you want refractive surgery? _____
 Do you have any special needs or concerns? _____



EYE HISTORY

Age that you first required glasses? _____ years old

Do you wear contact lenses? If so, do you sleep in them? What type? _____	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
Are you currently using reading glasses or bifocals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Do you have any known or suspected previous eye conditions?		<input type="checkbox"/> NO
<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Glaucoma (you or family)
<input type="checkbox"/> Lazy eye or strabismus	<input type="checkbox"/> Herpes Eye Infection	<input type="checkbox"/> Keratoconus
<input type="checkbox"/> Previous eye surgery	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Other _____

Has your vision prescription changed in the past few years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Have you had a laser vision correction consultation before?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Your regular eye doctor: _____

Your medical doctor: _____

MEDICAL HISTORY

Do you have any known or suspected medical conditions?		<input type="checkbox"/> NO
<input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pregnant or nursing
<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Keloid (scar) formation	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Other _____

Please list any drug allergies: _____

List any medications that you take (including: Accutane, Amiodarone, Imitrex): _____

Payment is requested at the time services are rendered, including insurance co-pays and non-covered service costs. I understand that it is my responsibility to be familiar with my insurance company's policies and to provide this office with the necessary insurance cards and referral forms.

I authorize you to release any information to my insurance company for the purpose of processing claims, this includes any HIV information.

Patient's Signature: _____ Date: _____