



FAIRFIELD COUNTY LASER VISION, LLC

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.

A Doctor _____ Magazine _____

Friend or Relative _____ Attended a Seminar _____

Office Personnel _____ TV/Radio _____

Newspaper _____ Brochure in Mail _____

Internet _____ 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? Yes No
 If so, do you sleep in them? Yes No
 What type? _____
 Are you currently using reading glasses or bifocals? Yes No

- Do you have any known or suspected previous eye conditions? NO
 Dry Eyes Eye Injury Glaucoma (you or family)
 Lazy eye or strabismus Herpes Eye Infection Keratoconus
 Previous eye surgery Cataracts Other _____

Has your vision prescription changed in the past few years? Yes No Not sure
 Have you had a laser vision correction consultation before? Yes No
 Your regular eye doctor: _____
 Your medical doctor: _____

MEDICAL HISTORY

- Do you have any known or suspected medical conditions?** NO
 Autoimmune disease Diabetes Pregnant or nursing
 Rheumatoid arthritis Psoriasis Heart Disease
 Keloid (scar) formation Hypertension 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: _____