

<b>For Office Use</b>				<b>INITIAL</b>
<b>REFERRAL NEEDED</b>	<b>DEDUCTIBLE</b>	<b>NO REFERRAL NEEDED</b>		
				<b>CO-PAY \$</b>

**PATIENT INFORMATION – PLEASE PRINT CLEARLY**

Name: \_\_\_\_\_ / \_\_\_\_\_ D.O.B: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: F / M  
 (Last Name) (First Name)  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Tel:H: \_\_\_\_\_ C: \_\_\_\_\_ W: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ SS: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital: S M W D

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Tel: \_\_\_\_\_

Primary Care MD: \_\_\_\_\_ Tel: \_\_\_\_\_ Eye Doctor: \_\_\_\_\_ Tel: \_\_\_\_\_  
 Date Letter sent to MD \_\_\_\_\_ Date Letter sent to OD \_\_\_\_\_

**How were you referred?** (circle) **A)** Another doctor sent me (who): \_\_\_\_\_  
**B)** Website: (which one): \_\_\_\_\_ Search engine (which): \_\_\_\_\_  
**C)** Friend/relative/colleague who had LASIK/Botox: \_\_\_\_\_ (name): \_\_\_\_\_  
**D)** Barter Network (which): \_\_\_\_\_ **E)** Print Ad (which: ) \_\_\_\_\_  
**F)** Auction / Fundraiser (which): \_\_\_\_\_ **G)** Other: \_\_\_\_\_

**What is the main benefit of LASIK / Botox that you want?** \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION (REQUIRED FOR ALL PATIENTS):**

We require insurance information from ALL our patients, even our LASIK/Botox patients. By providing us with this information, we can check to see if your insurance will pay or partially pay for your LASIK or Botox. In addition, if you have any valid medical insurance, you can use this insurance to pay for any additional treatments necessary to maximize your vision; for example, treatment for pre-existing dry eyes with punctal plugs or cautery.

**If your insurance pays partially, you will not be “balance billed” for the remainder, unless it is due to a deductible, coinsurance, and lack of eligibility. We will not bill your insurance without your permission.**

**It is your responsibility to get a referral from your insurance company if required. We will assist you with this.**

Name of Medical Health Insurance: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_  
 (Please indicate eye-only programs below; **Medical Health Insurance only in this section – insurance to see MDs**)

Name of responsible party: \_\_\_\_\_ DOB of responsible party: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

Claim Address (back of card): \_\_\_\_\_

**ANY SECONDARY INSURANCE (secondary coverage after primary Medicare or other health insurance; if you do not have Secondary insurance please put your vision insurance if any here:**

Name of Secondary plan or Vision Plan: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_

Name of Responsible Party: \_\_\_\_\_ DOB of Responsible party: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

Claim Address (back of card): \_\_\_\_\_

“I request that payment of my authorized Medicare or other insurance benefits be made to IWANT2020.COM for any services rendered to me by Dr. Chynn. My signature requests that payment be made, and authorizes the release of any information necessary by Dr. Chynn, his staff, and my carrier to file my claim, either in paper or electronic format. Dr. Chynn agrees to accept whatever amount my insurance pays for any services rendered, and not to bill me for any balance, unless it is due to a deductible, coinsurance, and lack of eligibility. If we are out of network with your insurance please ask us about this. If I am here for a regular office exam, I will be responsible for the co-pay. I agree to the terms the standard HIPPA Patient Privacy Policy used by IWANT2020.COM, a copy of which has been provided to me for review. “

Signed, \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

OPHTHALMIC HISTORY INFORMATION:

Do you wear: Glasses / Contacts - CIRCLE TYPE: - SOFT HARD/RGP

Are you pregnant or lactating? \_\_\_\_\_ If so, you should discuss your hormonal status with Dr. Chynn before proceeding with any LASIK procedure.

Are you currently taking any prescription eye drops or oral medications? If yes, please list: Brand name/generic name/condition

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Have you ever taken any of the following? LASIK is not recommended in patients taking the following medications due to scarring.

- Cordarone or Amiodarone       Accutane

Are you allergic to any medications? If yes, please list AND TELL DR. CHYNN AND HIS STAFF:

\_\_\_\_\_ No allergies: Circle: NKDA (No Know Drug Allergies)

Has anyone in your family had any of these eye problems?

- Diabetes      LASIK should not be performed in patients with uncontrolled diabetes/diabetic retinopathy
- Cataract      If you have severe cataracts, they should be removed instead of having LASIK
- Glaucoma      If you may have glaucoma, we will have to perform a visual field test before your LASIK
- Retinal tears      If you have a history of retinal problems, you will need retinal clearance before LASIK
- Other (please specify and TELL DR. CHYNN) \_\_\_\_\_

Do you now have or ever in the past had any of the following medical problems?

- Panic Attacks or Nervous Condition      May make operation more difficult—may need Valium preop.
- Severe Arthritis or Asthma      May make it difficult to lie flat for 15 min. during LASIK
- Epilepsy or Nystagmus      May make it difficult for you to fixate during operation
- HIV/AIDS or Herpes      Please tell Dr. Chynn so we make take proper precautions
- Psychiatric history or medications      Please mention to Dr. Chynn preoperatively
- Collagen vascular disease or keloids      May lead to scarring after surgery or require steroids

Other \_\_\_\_\_ Please discuss any important medical history with Dr. Chynn

Are you now, or have you in the past experienced any of the following eye problems?

- Serious eye infections       Halos or night glare (may persist after LASIK)
- Blurred Vision       Black Spots (floaters) or Flashing Lights
- Lazy eye or amblyopia       Retinal Problems
- Crossed eyes or double vision       Cataracts
- History of patching eye as a child       Glaucoma
- Eye Injuries \_\_\_\_\_       Eye Surgery \_\_\_\_\_

Please discuss with Dr. Chynn if you have checked ANYTHING on this list!

It is YOUR responsibility to TELL DR. CHYNN about any significant eye history or conditions you have, and to ask him specifically if these conditions can be addressed so that you can have the best possible visual outcome.

Your surgeon will be happy to discuss any special issues you may have, but you know your eyes and eye history best, as you have lived with them all your life! PLEASE LIST HERE any specific questions you wish to discuss:

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