Berks Eye
Physicians & Surgeons, Ltd.

LASIK Consultation - Patient Information

Patient's Name: _____ _____
First Middle Last Email Address

Address : _____
P.O. Box Street Address

_____
City State Zip

Telephone: _____ _____ _____
Home Work Cell

Date of Birth: _____ SS#_____ Marital Status: ☐ S ☐ M ☐ W Sex ☐ M ☐ F

Race: _____ Language: _____Family Doctor: _____

In case pre or post LASIK medical care is necessary and also to help you calculate any LASIK discounts available, we gather the following insurance information. **Your initial consultation is NO CHARGE to you or your insurance company.**

Insured/Responsible Party's Name: _____
First Last

_____
P.O. Box Street Address City State Zip

Date of Birth: _____ Relationship: _____ SS# _____

Primary Insurance Information

Name of Primary Insurance: _____

Secondary Insurance Information

Name of Secondary Insurance: _____

Tertiary/Vision Insurance Information

Name of Tertiary Insurance: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare / Other insurance company benefits be made either to me or on my behalf to Berks Eye Physician & Surgeons for any services furnished me by Berks Eye Physicians and Surgeons. Regulations pertaining to Medicare assignment of benefits apply. I authorize Berks Eye Physician & Surgeons to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare claims / other insurance company claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to Berks Eye Physicians and Surgeons. I understand it is mandatory to notify Berks Eye Physicians and Surgeons of any other party who may be responsible for paying for my treatment.

Signature: _____ Date: _____

Berks Eye
Physicians & Surgeons, Ltd.

Today's Date: _____

LASIK Consultation – Additional Information

Patient's Name: _____ _____
First Middle Last Date of Birth

Have you had any previous eye surgeries or problems: ☐ YES ☐ NO If YES, please detail below:

_____

_____

Other Health Problems: _____

Medications: _____

Have you ever had a LASIK Consultation before: ☐ YES ☐ NO

If YES, please detail feedback you received and where:

_____

_____

Do you have any allergies: ☐ YES ☐ NO If YES, please detail below:

_____

Do you wear Contact Lenses: ☐ YES ☐ NO If Yes, ☐ Soft Lenses ☐ Gas Permeable Lenses ☐ Hard Lenses

How long have you worn contact lenses: _____

How many hours per day do you wear contact lenses: _____

Do you sleep in your contact lenses: _____

Occupation: _____

In which of these activities do you participate: ☐ Swimming ☐ Jogging/Running ☐ Skiing ☐ Golfing
☐ Soccer/Rugby ☐ Baseball/Softball ☐ Basketball ☐ Biking

Other hobbies: _____

How did you hear of Dr. Izzo/Berks Eye for LASIK: ☐ Billboards ☐ Reading Eagle Post It Note ☐ Internet Search
☐ Friends/Family ☐ Insurance Provider ☐ Bodyzone
☐ Optometrist Referral ☐ Doctor Referral
☐ Other: _____

Expectations from Surgery: _____

_____