BALIN EYE & LASER CENTER

269 Locust Street
Northampton, MA 01060
413-584-6666

Welcome to the Balin Eye & Laser Center. Please take a few moments to complete this form.

1. Name _____ Date _____
   (Mr. Mrs. Ms. Dr.)
2. Address _____
   (Street) (City) (State) (Zip)
3. Telephone (Home) _____ Telephone (Work) _____
4. Cell # _____ May we contact you by e-mail? Yes No
   E-mail Address _____
5. Date of birth _____/_____/_____ Age _____ Social Security # _____
6. Single _____ Married _____ Widowed _____ Divorced _____ Separated _____
7. Employer _____ Occupation _____
8. Address _____
9. May we contact you at work: _____ Yes _____ No
10. Emergency contact _____ Phone_____
    Name Relationship
11. Primary care doctor _____
12. Name of current eye care provider _____
13. Name of pharmacy _____

Do you have an insurance benefit for laser vision correction? ____ Yes ____ No

If yes, please indicate name of insurance _____

How did you hear about us *(circle one)*?

Family/Friend * Doctor * Newspaper * Radio * Internet * Insurance List * Seminar/Health Fair

Other: _____ Whom may we thank for referring you? _____

I hereby understand that I am financially responsible for all expenses relative to the services performed by said doctor. I also understand that said services are not covered by insurance and payment will be due at the time of service.

Signed _____ Date _____

(Responsible party's signature)

Name: _____ Today's date: _____

Date of birth: _____ Social Security #: _____

Medical History Questionnaire

What is the purpose of your visit today? _____

Have you ever been told that you are not a good candidate for refractive surgery? Yes ☐ No ☐
If yes, why? _____

When are you interested in having the surgery?
Within 1 month ☐ Within 2-5 months ☐ Over 6 months ☐ Not sure ☐

List all medications and eye drops:
_____
_____
_____

Any allergies? Yes ☐ No ☐
If yes, what?
_____

Check any of the following you take:
Antihistamines ☐
Imitrex ☐
Accutane ☐
Amiodarone hydrochloride ☐
Hormone therapy ☐
Birth control ☐
Herbal supplements ☐

List illnesses & injuries (include dates)
_____
_____
_____

List all surgeries (include eye surgeries)
_____
_____
_____

Glasses:
No glasses worn ☐
Single vision ☐
Bifocal ☐
Progressive ☐
Reading glasses ☐

Contact lenses:
No contacts worn ☐
Daily ☐ Extended ☐
Soft ☐ RGP ☐ PMMA ☐ Toric ☐
Do you wear monovision with contacts?
Yes ☐ No ☐

Problems with night vision and/or glare? Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐ If yes, how many packs per day _____ per week _____
Do you drink? Yes ☐ No ☐ If yes, how many drinks per day _____ per week _____

Hobbies/interests: _____

_____

Balin Eye & Laser Center
Nancy A. Balin, M.D., F.A.C.S.

Balin Eye & Laser Center
Patient Consent For Use and Disclosure
Of Protected Health Information

I hereby give my consent for Balin Eye & Laser Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO)
(Balin Eye & Laser Center's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.
Balin Eye & Laser Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy practices may be obtained by forwarding a written request to Balin Eye & Laser Center, at 269 Locust Street, Northampton, MA. 01062

With this consent, Balin Eye & Laser Center may call my home or alternative location and leave a message on voice mail or in person in reference to any items that assist the practice of carrying about TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Balin Eye & Laser Center may mail to my home or alternative location any item that assist the practice in carrying out TPO, such as reminder appointment cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Balin Eye & Laser Center may E-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Balin Eye & Laser Center restrict how it uses or discloses my PHI to carry to TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Balin Eye & Laser Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Balin Eye & Laser Center may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient Name Date

_____
Print Name of Patient or Legal Guardian