Four Corners Eye Clinic
SPECIALIZING IN MEDICAL AND SURGICAL EYE CARE

Eric C. Meyer, M.D.
Joshua P. Zastrocky, M.D.
John P. Brach, M.D.
Karyn Teel, M.D.
David W. Bishop, M.D.

Dear Patient,

Thank you for choosing Four Corners Eye Clinic to evaluate your cataracts. Our practice has been serving the Four Corners Community since 1992 and together our physicians have over twenty-five years of experience performing cataract surgery. As the Four Corners only multi-specialty Ophthalmology practice, our fellowship trained Glaucoma and Retina specialists are also available to you in order to diagnose and treat a full spectrum of medical and surgical eye care needs.

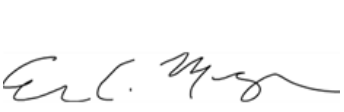
During your upcoming appointment, several things will take place: some measurements will be taken, your eyes will be dilated, and you will meet with the doctor and his staff to discuss the stage of your cataracts and your various surgical and lens implant options. After a decision for surgery is made, we will take the next steps in scheduling your surgery and future appointments. Expect to be in our office for 1 to 1 ½ hours to complete the entire process.

We have enclosed some informational booklets that should be helpful as you start to educate yourself about the various choices available to you for custom cataract correction. Reading through the information will help you think of questions you may have for the surgeon. It will also help you understand lifestyle lens options that can eliminate or decrease your dependency on glasses following cataract surgery.

We have also included some information to complete prior to arriving at our office. For your convenience we have included a self-addressed, stamped envelope. Having this information in advance will help us prepare for your visit. In the event you and your physician decide on surgery, having these forms completed will expedite the process of scheduling surgery. Please complete and return the following items: Welcome to Four Corners Eye Clinic; Patient Information; Pre-Surgical Cataract Patient Questionnaire; Vision Lifestyle Survey; Advanced Refractive Testing Acknowledgement; Current Patient Medications; and Pre-Surgical Questionnaire from Animas Surgical Hospital.

Our team looks forward to meeting your vision needs!

Sincerely,



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Welcome to Four Corners Eye Clinic!

We are happy you have chosen Four Corners Eye Clinic as your eye care provider. Please read the important notifications below, and sign the acknowledgement on the last page. This will help you become familiar with our practice policies.

OUR MISSION & YOUR FEEDBACK

We are constantly working to maintain and improve on our services to you. Four Corners Eye Clinic is committed to providing outstanding, quality, comprehensive eye care in a caring, professional environment. Shortly after your appointment, you will receive an invitation to participate in a brief on-line or telephone survey about your experience. You will receive an invitation by email, text and/or telephone. If you would prefer not to participate there will be an opportunity to opt-out and prevent future invitations. Also, our staff welcomes your feedback at any time during or after your visit to our office. Thank you for trusting our physicians and staff to care for your eye health and vision.

KEEPING INSURANCE INFORMATION UP TO DATE

It is the patient's responsibility to provide our office with accurate, up-to-date insurance information. If you do not provide our office with your current insurance information at the time of service, you will be responsible for payment at the time of service. Additionally, insurance companies have time limits on how long a provider can take to bill a claim. If a claim is not sent in a timely manner, it will be denied. If a claim is denied for untimely filing through no fault of our office, the charges will become the patient's responsibility.

INSURANCE REFERRALS / AUTHORIZATIONS

It is **always** the patient's responsibility to ensure that they have a valid referral/authorization for services rendered at each visit, if your Insurance Plan requires a referral/authorization. Should you arrive at the clinic WITHOUT a valid referral/authorization for that day's visit, you have the option of:

1) Contacting your insurance company to arrange for an immediate referral/authorization to be faxed to our office;
2) Being seen as a Self Pay visit and filing on your own to your insurance plan; or
3) Rescheduling your appointment. Unfortunately our clinic staff cannot contact your Insurance Carrier to obtain your referral/authorization for benefits.

MEDICAL EXAMINATIONS AND TREATMENT VS. VISION PLAN (ROUTINE) EXAMINATIONS

All doctors at our practice are medical doctors. Therefore, we bill medical insurances, not vision plans. The appointment is a "medical eye exam" not a "vision exam". When sending a claim to the patient's insurance company, our records will indicate that the patient was seen for a medical reason and has received a medical diagnosis. Our office generally will NOT send the claim under a "routine eye exam" diagnosis. Additionally, we cannot change the diagnosis on a claim in order to receive payment. All diagnoses must be documented in the patient's chart.

PLEASE CONTINUE TO THE BACK OF THIS FORM

INSURANCE ASSIGNMENT AND RELEASE; MEDICARE/MEDGAP AUTHORIZATION

I certify that I have insurance coverage with the company(ies) I provided and assign directly to the physician(s) at and Four Corners Eye Clinic, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. The current physicians at Four Corners Eye Clinic include: Eric Meyer, M.D., Joshua Zastrocky, M.D., John Brach, M.D., and Karyn Teel, M.D. . I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I authorize the use of my signature on all insurance submissions.

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made to Four Corners Eye Clinic for any services furnished to me. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

REFRACTIONS (TEST FOR BEST CORRECTED VISION)

Refractions are not covered by Medicare or most medical insurance plans. Refraction fees are the responsibility of the patient. The fee is due and payable whether or not you receive a written glasses prescription. Refraction is a test for best corrected Visual Acuity and/or a Glasses Prescription. This test is often performed as a part of your annual eye exam. Vision changes can be a symptom of other conditions related to the eye beyond needing glasses. Therefore, we generally do not perform Refractions without an examination by one of our physicians. Fees may change from time to time, with or without notice. **Our current Refraction Fee is $40.00. Please inquire with our staff at the time of your service for our fee at that time.**

ARRIVAL TIMES & APPOINTMENT REMINDERS

Please arrive promptly at your arrival time. When scheduling an appointment we will provide you with an arrival time at our office. The arrival time provides us with the opportunity to have you complete paperwork, have testing completed and when appropriate, your eyes dilated prior to seeing the physician. Patients who arrive later than their scheduled arrival time may be asked to reschedule.

We do our best to remind you of your upcoming appointment and the arrival time. Our reminders will come to you through an automated phone call and/or email. Both the time we provide you for your appointment and when you receive a reminder message are the time we ask you to arrive at our office.

DILATION

Please note that your eyes may be dilated during your examination. Dilation of your pupils may blur your vision and make you sensitive to light for several hours after your examination. It is important to refrain from driving and performing precision work with tools when your vision is blurred from dilation. It is not possible to predict how long the effect of dilation will last or how much your vision will be affected. We recommend that you wear sunglasses when your eyes are dilated. Please ask the checkout staff for a complimentary disposable pair of sunglasses if you do not have yours with you. You may consider arranging for someone to drive you after your appointment.

PLEASE CONTINUE TO THE NEXT PAGE OF THIS FORM

PHARMACY PRESCRIPTIONS & REFILLS

You may be given a prescription for medication or medication refills in conjunction with your care. It is important that you check with your pharmacist and/or primary care physician regarding potential interactions with other medications you are currently taking. Our doctors also recommend that you check with www.prescribingreference.com to become aware of all potential risks/benefits and interactions for all medications. **For prescription refills, please contact your pharmacy first.** They will relay your request to us. We encourage our patients to plan ahead and notify your pharmacy at least 48 hours in advance when you require a prescription refill. If 48 hours passes after you contact your pharmacy, please call our office for further assistance.

ACCESSING YOUR HEALTH INFORMATION VIA WEB PORTAL

You have the opportunity to view certain health information from your visits to our office through a web portal. When you provide us with your email address, you will receive an email with instructions for accessing this information following your visit to our office. In the future, when there are new visits or certain health information is updated you will receive an email to notify you that there is new information available. Also, on your patient information form you may indicate that you would like to receive clinical reminders by email which will direct you to the web portal. If you do not provide us with your email address, you may request instructions from our office to access your web portal. If you have trouble accessing your information, our office can reset your log in information.

ADMINISTRATIVE FEES / MEDICAL RECORDS

There is a minimal clerical charge of $15 for any administrative form the office completes which is not already included in the fee for your medical exam. This includes and is not limited to the following: disability forms, vision forms, DMV vision forms, jury service, or supplemental insurance forms. Medical Records requests are prepared and fulfilled in accordance with Colorado law. Administrative fees may be charged in the preparation of medical records. Please ask for a copy of our current process for Medical Records Requests and Fees. In general, it takes approximately thirty (30) days to respond to a medical records request. Should we incur a bounced check from our bank, we will pass that on to you, as well as an administrative fee of $25.

CANCELLATION FEES

Kindly give 24-48 hours' notice if you are unable to keep your appointment, so that we may book another patient who needs our care in that time slot. A $25 cancellation fee may be applied to your account if we are not informed of your cancellation/need to reschedule within 24 hours of your scheduled appointment.

BILLING STATEMENT FEES & TIMELY PAYMENT DISCOUNTS

All collection costs, attorney's fees, and court costs are the responsibility of the patient. Should a Self-Pay service not be paid in full at the time of service, a $30 billing fee may be assessed to the patient's account. A $5.00 per month statement fee will be assessed on all accounts over 30 days past due, to the full extent allowed by law. From time-to-time Four Corners Eye Clinic may offer a discount to patients without insurance when their balance is paid on the date of service. Please inquire prior to leaving about how to receive a discount. Failure to pay on the date of service will result in the full billed charge being owed.

PLEASE CONTINUE TO THE BACK OF THIS FORM

CoPays, Deductibles, and Non-Covered Services

I acknowledge that I am financially responsible for copays, deductibles and non-covered services, and that those amounts will be collected at the time of service.

Billing and Collections

I acknowledge that Four Corners Eye Clinic is providing services in good faith and that it will be appropriately compensated in a timely manner. If necessary, the patient and/or guarantor will be held liable for any late fees, interest, collection fees, and/or reasonable attorneys' fees for the prosecution and/or collection of the patient amount owed. It is the patient's and/or guarantor's responsibility to provide Four Corners Eye Clinic with updated billing and insurance information on each and every visit.

I consent to be contacted by regular mail, by e-mail or by telephone (including a cell phone number), as well as the use of technology including auto-dialing and/or prerecorded messages in contacting me regarding any matter related to my account by Four Corners Eye Clinic or any entity to which Four Corners Eye Clinic assigns my account. I also consent to the use of any updated or additional contact information that I may provide.

Notice of Privacy Practices

I have received the Notice of Privacy Practices for Four Corners Eye Clinic. P.C.

By signing below, I acknowledge receipt of the above information, including general policies, financial policies and receipt of Notice of Privacy Practices.

_____ _____

Patient and/or Responsible Party Name (Please Print) Date of Birth

_____ _____

Patient and/or Responsible Party Signature Today's Date

Four Corners Eye Clinic
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Patient Information

Your Information

Last Name:_____ First:_____ Mi:_____

Social Security No:_____

Mailing Address:_____
Street or PO Box *Apt.* *City* *State* *Zip*

Home Address:_____
(If different than mailing) *Street or PO Box* *Apt.* *City* *State* *Zip*

Sex: M / F Date of Birth:_____ Preferred Nickname:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____)_____ Fax Number: (_____)_____

Preferred Phone #: ☐ Home ☐ Cell ☐ Work

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ White
☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Preferred Contact for Clinical Reminders About Your Care:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Fax ☐ Email (via Patient Portal) ☐ Mail ☐ Do Not Contact
(We will call your preferred phone number to remind you of upcoming appointments. Examples of clinical reminders may include taking your medications, following up on recommendations given by your physician, etc.)

Preferred Pharmacy

☐ Albertsons (Durango) ☐ Albertsons (Farmington) ☐ City Market (Cortez)
☐ City Market (Durango, North) ☐ City Market (Durango, South) ☐ City Market (Pagosa Springs)
☐ Jackisch Drug (Pagosa Springs) ☐ Indian Health Services (Shiprock) ☐ Indian Health Services (Towaoc)
☐ Mill Street (Bayfield) ☐ Rite Aid (Durango) ☐ Rivergate (Durango)
☐ Safeway (Aztec) ☐ Safeway (Cortez) ☐ Southern Ute Health (Ignacio)
☐ Target (Farmington) ☐ Walgreens (Cortez) ☐ Walgreens (Durango)
☐ Walgreens (Farmington, 20th) ☐ Walgreens (Farmington, Main) ☐ Walmart (Cortez)
☐ Walmart (Durango) ☐ Walmart (Farmington, 1400 Main, aka "West")
☐ Walmart (Farmington, 4600 Main, aka "East")

☐ Other Pharmacy: _____

THIS IS A TWO-SIDED / TWO PAGE FORM, PLEASE COMPLETE AND SIGN PAGE 2

Four Corners Eye Clinic
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Patient Information

Emergency Contact

Emergency Contact:_____ Contact's Phone: (_____)_____

Relationship to Emergency Contact: _____

Your Employment Information

Employer:_____ Occupation:_____

Employer Address:_____

Street or PO Box *Apt.* *City* *State* *Zip*

Insurance Information

Please list both your primary and secondary insurance, if applicable. Please provide copies of all insurance cards. We will verify that your insurance coverage is current. In the event we are unable to verify your coverage, you will be responsible for your charges until we are able to verify your coverage.

Primary Insurance Plan Name: _____

Secondary Insurance Plan Name: _____

Subscriber Name (If Different From Patient): _____

Social Security No:_____ Date of Birth:_____

Relationship to Primary Insured (Circle One): Self Spouse Daughter Son Other

Responsible Party

If the patient is a minor or there is another person who is financially responsible for the charges other than the patient, please complete the section below. When the patient is not a minor and the information below is blank and/or the patient is the only signor, the patient will be the responsible party.

Responsible Party (If Different From Patient):_____

Social Security No:_____ Date of Birth:_____

Home Phone:_____ Work Phone:_____

Home Address:_____

Street or PO Box Apt. City State Zip

Mailing Address:_____
(If Different) Street or PO Box Apt. City State Zip

Your Signature below indicates that this information is correct and accurate.

Patient Signature:_____ Date:_____

Responsible Party Signature:_____ Date:_____

(If different than patient. If Responsible Party Signature is blank, the patient is the responsible party.)

Four Corners Eye Clinic

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Preparing for Your Cataract Pre-Op Appointment

1. **Discontinue contact lens wear.**
   If you wear contact lenses, you must discontinue wearing your lenses PRIOR to your preoperative appointment! This is necessary to obtain the most accurate measurements possible so that you can get your best possible surgical result. The following standards apply:

Type of Contact Lens	Discontinue Wear
Rigid or Soft Toric Contacts	4 Weeks Before Pre-Op Appointment
Soft Contacts	2 Weeks Before Pre-Op Appointment

2. **Please inform us if you have had previous LASIK, PRK, or RK surgery.**
   At the time of your appointment you will be asked if you had any of the previous refractive surgeries. If so, we will ask you for a copy of your medical records from your refractive surgery. This will help us plan for your surgery, the options available to you for lifestyle lenses and ensure the best possible outcome from cataract surgery.

3. **Start using artificial tears.**
   The use of an artificial tear drop prior to preoperative testing has been proven to provide better surgical outcomes. Start using any over-the-counter artificial tear two weeks before your scheduled appointment(NO Visine or anything that claims to remove redness). Our office generally recommends Refresh, Systane or TheraTears. We likely have included a coupon for one or more of these options along with this packet of information.

   Starting two weeks before your scheduled appointment, use 1 drop of artificial tear in each eye, 4 times a day. You may discontinue these tears after your pre-op appointment. If your appointment in less than two weeks away please being using artificial tears as soon as possible.

Directions for Inserting Eye Drops

While putting drops in your eyes may seem difficult at first, it becomes easier with practice and following these helpful hints. Wash your hands before using drops. Remove the cap. Do not touch the dropper tip. Tilt your head back slightly. Pull your lower lid away from your eye to form a pocket by either pulling the lower lid down with index finger or pinching the lower lid outward using the thumb and forefinger. Look up and let the drop fall into the pocket without touching the dropper tip to your eye or eyelid(to prevent contamination).
If using more than one type of drop, allow 5 minutes between.

4. **Payment for elective lens costs and self-pay services.**
   Amounts due from the patient prior to surgery such as elective lens costs or full surgical costs due to non-insured status will be due no later than 2 weeks prior to surgery. This includes surgical packages that are intended to correct for astigmatism or presbyopia. Surgery will be cancelled if payment is not received in a timely manner. ANY change in lens implant selection by the patient may necessitate a return visit to our office for a scheduled appointment prior to surgery to repeat pre-surgical measurements and sign new consent forms.

Pre-Surgical Cataract Patient Questionnaire

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VISUAL FUNCTIONING

Do you have difficulty, even with glasses, with the following activities?	YES	NO	Right Eye	Left Eye	Both Eyes
1. Reading small print, such as labels on medicine bottles, telephone books, or food labels?	☐	☐	☐	☐	☐
2. Reading a newspaper or book?	☐	☐	☐	☐	☐
3. Reading a large-print book, or large-print newspaper, or large numbers on a telephone?	☐	☐	☐	☐	☐
4. Recognizing people when they are close to you?	☐	☐	☐	☐	☐
5. Seeing steps, stairs or curbs?	☐	☐	☐	☐	☐
6. Reading traffic signs, street signs, or store signs?	☐	☐	☐	☐	☐
7. Doing fine handwork like sewing, knitting, crocheting, or carpentry?	☐	☐	☐	☐	☐
8. Writing checks of filling out forms?	☐	☐	☐	☐	☐
9. Playing games such as bingo, dominos, or card games?	☐	☐	☐	☐	☐
10. Taking part in sports like bowling, handball, tennis or golf?	☐	☐	☐	☐	☐
11. Cooking?	☐	☐	☐	☐	☐
12. Watching television?	☐	☐	☐	☐	☐

SYMPTOMS

Have you been bothered by:	YES	NO	Right Eye	Left Eye	Both Eyes
1. Poor night vision?	☐	☐	☐	☐	☐
2. Seeing rings or halos around lights?	☐	☐	☐	☐	☐
3. Glare caused by headlights or bright sunlight?	☐	☐	☐	☐	☐
4. Hazy and/or blurry vision?	☐	☐	☐	☐	☐
5. Not seeing well in poor or dim light?	☐	☐	☐	☐	☐
6. Poor color vision?	☐	☐	☐	☐	☐
7. Double vision?	☐	☐	☐	☐	☐

DRIVING

1. Have you ever driven a car? ☐ YES (continue) ☐ NO (stop)
2. Do you currently drive a car? ☐ YES (continue and skip #5) ☐ NO (skip to #5)
3. How much difficulty do you have <u>driving during the day</u> because of your vision?
   ☐ No difficulty ☐ A moderate amount of difficulty
   ☐ A little difficulty ☐ A great deal of difficulty
4. How much difficulty do you have <u>driving at night</u> because of your vision?
   ☐No difficulty ☐ A moderate amount of difficulty
   ☐ A little difficulty ☐ A great deal of difficulty
5. When did you stop driving?
   ☐ Less than 6 months ago ☐ 6-12 months ago ☐ More than 1 year ago

Cataract surgery can almost always be safely postponed until you feel you need better vision. If stronger glasses will not improve your vision any more, and if the only way to help you see better is cataract surgery, do you feel your vision problem is bad enough to consider surgery now?

☐ YES ☐ NO

Patient Signature: _____ Date: _____

Revised 3/14/2018

Vision Lifestyle Survey

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We want to help you maintain excellent vision. The term "cataracts" refers to a cloudy lens within the eye. When a cataract is removed, a lens implant is used to replace the cloudy natural lens. If it is determined that a lens implant is appropriate for you, your answers below along with results from your tests will help in determining which implant best suits the demands of your lifestyle. Please fill out completely and return to our office.

1. If a lens replacement is recommended for you, please rate your vision preference at the following distances:

   Distance Vision: driving, golf, tennis, other sports, watching TV
   ☐ Prefer no distance glasses ☐ I would not mind wearing glasses for distance

   Mid-range Vision: computer, menu, price tags, cooking, board games
   ☐ Prefer no mid-range glasses ☐ I would not mind wearing mid-range glasses

   Near Vision: reading books and newspapers, doing detailed handheld work
   ☐ Prefer no near glasses ☐ I would not mind wearing near glasses

2. Please check the single statement that best describes you in terms of night vision:
   ☐ Night vision is extremely important to me and I require the best possible quality;
   ☐ I want to be able to drive comfortably at night but I would tolerate some slight imperfections;
   ☐ Night vision is not important to me.

3. If you had to wear glasses after surgery for only one activity, for which type of activity would you be most willing to wear glasses?
   ☐ Distance Vision (driving, watching TV)
   ☐Mid-range Vision (computer, dashboard)
   ☐ Near Vision (reading fine print)

4. IF you could have good distance vision during the day without glasses and good near vision for reading without glasses, but the compromise was that you might see some halos or rings around lights at night, would that be okay?
   ☐ Yes ☐ No

5. If you could have good distance vision and mid-range vision during the day and night without glasses, but the compromise was that you might need glasses for reading the finest print at near, would you like that option?
   ☐ Yes ☐ No

6. How many hours per day to you spend:
   _____ on the computer?
   _____ reading books, newspapers, or small print?
   _____ driving?

7. List your favorite hobbies or work activities:

8. Place an 'X' on the scale to describe your personality as best you can:

   |----------|
   Easygoing Perfectionist

Signature: _____ Date: _____

Revised 3/14/2018

Advanced Refractive Testing (iTRACE) Acknowledgement

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Thank you for choosing one of the surgeons at Four Corners Eye Clinic, P.C.

We are excited to tell you that we are the first practice in SW Colorado to offer the latest iTrace Wave-Front no touch eye exams. With this new technology, we can assess your vision for higher order aberrations that may be causing you to see distortions such as "ghost images", double vision, halos, streaking of light and glare. We are able to analyze the eye in several different layers to assess the source of distortion then present to you the best treatment options for your eyes. Our physicians will be able to see what a point of light looks like through your eyes and what the potential is when surgically or non-surgically (eyeglasses or contacts) corrected. In addition, we will be able to see a map of the surface of your cornea which can aid in the diagnosis and treatment of many corneal dystrophies.

One of the benefits of choosing our practice for cataract surgery is the availability of advanced diagnostic testing through iTRACE. Our surgeons recommend using the data from iTRACE as a part of planning for cataract surgery and your lens selection. Among other information, the test collects abberometry data which helps objectively measure the quality of your vision.

The test is not covered by Medicare and most insurance. *The cost for the test is $100 per eye*. We offer a 25% discount when payment is made on the day of service.

Please indicate if you prefer to have this test completed:

- ☐ Complete iTRACE test;
- ☐ Decline iTRACE test

Patient Signature:_____ Date:_____

Revised: 3/22/2016

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CURRENT PATIENT MEDICATIONS

Instructions for Patients:

- Below, please list all current medications including over the counter (OTC) and alternative medications (OTC and Alternative medications will not be continued on admission to the hospital).
- For each medication, please list the name, dose, route (how you take the medicine, for example by mouth, injection, etc) and frequency (how often, for example every 8 hours, every morning, every day, etc).

Patient Name_____ **Date of Birth**_____

Name of Pharmacy_____

Pharmacy Location_____

Home / Prior to Admission Prescription Medications – List Below OR ☐ NONE				
Medication Name	**Dose**	**Route**		**Frequency**
1.		☐ By Mouth ☐ Injection	☐ Eye Drop ☐ Other _____	every
2.		☐ By Mouth ☐ Injection	☐ Eye Drop ☐ Other _____	every
3.		☐ By Mouth ☐ Injection	☐ Eye Drop ☐ Other _____	every
4.		☐ By Mouth ☐ Injection	☐ Eye Drop ☐ Other _____	every
5.		☐ By Mouth ☐ Injection	☐ Eye Drop ☐ Other _____	every
6.		☐ By Mouth ☐ Injection	☐ Eye Drop ☐ Other _____	every
7.		☐ By Mouth ☐ Injection	☐ Eye Drop ☐ Other _____	every
8.		☐ By Mouth ☐ Injection	☐ Eye Drop ☐ Other _____	every
9.		☐ By Mouth ☐ Injection	☐ Eye Drop ☐ Other _____	every
10.		☐ By Mouth ☐ Injection	☐ Eye Drop ☐ Other _____	every

Vitamins, Over the Counter (OTC), Herbal, Homeopathic – List Below OR ☐ NONE				
Medication Name	**Dose**	**Route**		**Frequency**
11.		☐ By Mouth ☐ Injection	☐ Eye Drop ☐ Other _____	every
12.		☐ By Mouth ☐ Injection	☐ Eye Drop ☐ Other _____	every

ANIMAS SURGICAL HOSPITAL

** PLEASE fill out this form COMPLETELY**

COMPLETE QUESTIONNAIRE MUST ACCOMPANY SURGICAL SCHEDULING FORM - THANK YOU

NAME: _____ **AGE:** _____ **DOB:**_____ **HEIGHT:**_____ **WEIGHT:**_____

SURGEON:_____ **SURGERY:**_____ **DATE OF SURGERY:**_____

Who is filling out this form: □ **Patient** □ **MD office** **Primary Care Physician:**_____ **Cardiologist:**_____

LIST ALL ALLERGIES TO MEDICATIONS	LIST ALL PREVIOUS SURGERIES OR PROCEDURES REQUIRING SEDATION

□ **YES** □ **NO** **Do you have an allergy to Latex?** **What type of reaction do you get (rash, hives, etc)?** _____

□ **YES** □ **NO** **Have you ever had anesthesia** □ **YES** □ **NO** **Have you ever had problems with anesthesia**

□ **YES** □ **NO** **Have you or a relative ever been diagnosed with Malignant Hyperthermia (MH) ?** **Whom:** _____

□ **YES** □ **NO** **Do you have a history of MRSA? Describe:**

CHECK ALL THAT APPLY TO YOU NOW OR IN THE PAST

CARDIOVASCULAR			RESPIRATORY			GASTROINTESTINAL		
□ YES	□ NO	High Blood Pressure	□ YES	□ NO	Can you walk up 2 flights of stairs?	□ YES	□ NO	Ulcer
□ YES	□ NO	Palpitations/Irregular Heart Beat	□ YES	□ NO	Asthma/Wheezing	□ YES	□ NO	Hiatal Hernia
□ YES	□ NO	Valve Prolapse	□ YES	□ NO	Emphysema	□ YES	□ NO	Frequent Heartburn
□ YES	□ NO	Heart Murmur	□ YES	□ NO	Bronchitis	□ YES	□ NO	Acid Reflux
□ YES	□ NO	Congestive Heart Failure	□ YES	□ NO	Sleep Apnea _____ CPAP use	□ YES	□ NO	Other GI Disease
□ YES	□ NO	Stent(s) - Year _____	□ YES	□ NO	Blood Clots in Lungs (embolism)	□ YES	□ NO	Hepatitis-Type_____
□ YES	□ NO	Angioplasty - Year _____	□ YES	□ NO	Allergies/Sinusitis	□ YES	□ NO	Other Liver Disease
□ YES	□ NO	Pacemaker/Defibrillator	□ YES	□ NO	Home Nebulizer use____	□ YES	□ NO	Can you eat/drink?
□ YES	□ NO	Arrhythmias (type) _____	**ENDOCRINE**			**GENITOURINARY**		
□ YES	□ NO	Coronary Artery Bypass Grafts	□ YES	□ NO	Diabetes - Year Diagnosed ____	□ YES	□ NO	Kidney Failure
□ YES	□ NO	Heart Attack - Year _____	□ YES	□ NO	Insulin? Type _____	□ YES	□ NO	Kidney Stones
□ YES	□ NO	Angina/Chest Pain	□ YES	□ NO	Thyroid: Hyper or Hypo	□ YES	□ NO	Frequent Urinary Infections
□ YES	□ NO	Dates of Chest Pain:_____	□ YES	□ NO	Steroid Medications in Past Year	□ YES	□ NO	BPH
□ YES	□ NO	High Cholesterol	□ YES	□ NO	Other Endocrine Diseases	□ YES	□ NO	Dialysis
□ YES	□ NO	Blood Clots in Legs	**ASSISTIVE DEVICES**			**BLOOD**		
□ YES	□ NO	Coronary Artery Disease	□ YES	□ NO	Dentures - Full Set	□ YES	□ NO	Bleeding Disorder
□ YES	□ NO	Rheumatic Fever	□ YES	□ NO	Partial - Bridge	□ YES	□ NO	Sickle Cell
NEUROLOGIC			□ YES	□ NO	Contact Lens	□ YES	□ NO	Hemophilia
□ YES	□ NO	Seizures/Epilepsy	□ YES	□ NO	Hearing Aid	□ YES	□ NO	Other Blood Disease
□ YES	□ NO	Stroke/Paralysis/TIA	□ YES	□ NO	Eye Glasses	□ YES	□ NO	Blood Clots (legs, lungs, other)
□ YES	□ NO	Muscle Weakness	**OTHER**			□ YES	□ NO	Blood Transfusion- Year ____
□ YES	□ NO	Spinal Cord Abnormality	□ YES	□ NO	Arthritis	**PSYCHIATRIC**		
□ YES	□ NO	Headaches or Migraines	□ YES	□ NO	TMJ	□ YES	□ NO	Anxiety
□ YES	□ NO	Other Neuro Disease? Type	□ YES	□ NO	Cataracts/Glaucoma	□ YES	□ NO	Depression
FEMALES ONLY			**PEDIATRIC PATIENTS**			□ YES	□ NO	Bipolar Disorder
□ YES	□ NO	Pregnant (current)	□ YES	□ NO	Premature Birth	□ YES	□ NO	Schizophrenia
□ YES	□ NO	Lactating/Breastfeeding	□ YES	□ NO	Developmental Delay	□ YES	□ NO	Panic Disorder
□ YES	□ NO	Tubal Ligation/sterilization	□ YES	□ NO	Family history of muscle disease	□ YES	□ NO	Other Specify:_____
□ YES	□ NO	Hysterectomy	□ YES	□ NO	Parental Custody	**CANCER**		
Date Last Period _____			If NO, who has custody _____			Type/treatment: _____		

PRE-SURGICAL EVALUATION FORM CONTINUED

RECENT ILLNESS

Have you been sick recently? □ YES □ NO If YES please describe : _____

Have you notified your surgeon's office? □ YES □ NO

PAIN

Are you currently in Pain? □ YES □ NO Rate pain on Scale 1-10 (10 is worst): _____

Location: _____ Describe: □ sharp □ dull □ aching □ stabl □ shooting

FALLS/SAFETY

Have you fallen in the last 3 m □ YES □ NO Do you use a cane/crutches/walker? □ YES □ NO

Do you have impaired mobility □ YES □ NO

ALCOHOL/TOBACCO

Have you ever sm □ YES □ NO Packs per day: ____ How many years: _____ Year Quit: _____

Do you drink alcc □ YES □ NO Drinks per week: _____

Do you use Mariju □ YES □ NO Do you use street drugs? □ YES □ NO Specify: _____

INFECTIOUS DISEASE HISTORY

MRSA □ YES □ NO Hospital acquired infection (C-Diff/other): _____

HIV/AIDS □ YES □ NO Hepatitis (type): _____ □ YES □ NO

TB □ YES □ NO Non healing wounds/sores : _____

IMMUNIZATION HISTORY

Pneumonia Vaccine: □ YES □ NO If YES provide date/year (or appx):_____ □ Declined

Flu Vaccine: □ YES □ NO If YES provide date/year (or appx):_____ □ Declined

Tetanus, Diphtheria, Pertussis □ YES □ NO If YES provide date/year (or appx):_____ □ Declined

FAMILY HISTORY (LIST ANY SIGNIFICANT HISTORY)

Mother/Father: _____

Brother/Sister/Son/Daughter: _____

Demographic Data

Race: □ American Indian or Alaska native □ Asian □ Black □ Hawaiian/ Pacific Islander

□ White or Caucasian □ Some other race

Ethnicity □ Hispanic/Latino □ Not Hispanic/Latino □ Decline to answer

Preferred Language: _____ Do you feel safe at home? □ YES □ NO

DISCHARGE PLANNING

Do you have help at home post-surgery? □ YES □ NO Do you have home heatlh currently: _____

Describe support system/lack of support: _____

ADVANCED DIRECTIVES

Do you have an Advanced Dir □ YES □ NO IF YES, type: □ Living Will □ POA □ Psychiatric

If NO, has information been requested: □ YES □ NO Please bring in DOS if you wish to have on record

EMERGENCY CONTACT

Name: _____ Relation: _____ Phone Number: _____

DAY OF SURGERY CONTACT INFORMATION

Who will be driving you home after your surgery? Name: _____

Relationship: _____ Phone Number:_____

Best phone number you can be reached at: _____ Can we leave a message? □ YES □ NO

Reviewed by RN: _____ Entered in NG: _____

Four Corners Eye Clinic
SPECIALIZING IN MEDICAL AND SURGICAL EYE CARE

Eric C. Meyer, M.D.
Joshua P. Zastrocky, M.D.
John P. Brach, M.D.
Karyn Teel, M.D.
David W. Bishop, M.D.

Type of Lens*	Description	Near	Intermediate	Distance	Astigmatism
Monofocal Normally covered by insurance and Medicare	Improved distance OR near vision; Cost usually covered by insurance and Medicare; May require glasses for close-up vision			* **(or near if desired)**	
Toric Out of pocket cost (not covered by insurance) is $1,425 ($800 to our office and $625 to the hospital) per eye	Improved distance OR near vision usually without glasses for astigmatic patients; May required glasses for close-up vision			* **(or near if desired)**	*
ReSTOR Out of pocket cost (not covered by insurance) is $2,300 ($1,200 to our office and $1,100 to the hospital) per eye	Improved distance AND near vision; Reduces the reliance on glasses; May experience glare/halos around lights; May experience difficulty in low light situations	*	*	*	

** These lens options are subject to you being a suitable candidate for the lens and affording the associated out of pocket expenses which may include deductibles, co-insurance and non-covered benefits. You and your surgeon will talk about suitable options for your needs.*

Revised 3/14/2018