WELCOME TO THE OFFICE OF KORAY ARIN O.D.

Today's Date ________________

PATIENT INFORMATION

Last Name______________________________First Name______________________
Address_________________________________City______________ST____Zip____
Date of Birth_______________ Phone__________________
Email____

REASON FOR TODAY'S VISIT Date of Last Eye Exam_____________

__Glasses/Routine Eye Examination __Refractive Surgery (LASIK) Evaluation

__Contact Lens Examination ***Additional fees will apply*

__Retinal Imaging ***Additional fees will apply*

MEDICAL & EYE HISTORY

Please indicate if you or any member of your family have the following:

High Blood Pressure	__Yes	__No	__family member, who?_______________
Diabetes	__Yes	__No	__family member, who?_______________
Heart Disease	__Yes	__No	__family member, who?_______________
High Cholesterol	__Yes	__No	__family member, who?_______________
Cancer	__Yes	__No	__family member, who?_______________
Glaucoma	__Yes	__No	__family member, who?_______________
Cataracts	__Yes	__No	__family member, who?_______________
Inherited Diseases	__Yes	__No	__family member, who?_______________
Allergies	__Yes	__No	__family member, who?_______________

Any other health problems ____
Any other eye problems/surgeries____
Are you pregnant? __Yes __No

Did you have LASIK? __Yes __No When?___________

List any medications you are taking:____
____

Allergies to any medications?____
Do you use cigarettes/tobacco?__________Alcohol?__________Other substances?______

CONTACT LENS INFORMATION

Do you wear contact lenses? __Yes __No
If yes: Soft _______ Hard/Gas Permeable__________
Disposable__________ How often do you change your lenses?_______________
I sleep in my contacts __Yes __No How many days maximum?____________________

**A contact lens exam includes an additional evaluation fee that is not covered by insurance carriers. This evaluation is necessary if you would like a contact lens prescription. This fee will vary between $70 -$165 depending on your contact lens needs & will be expected to be paid today.

INSURANCE INFORMATION

Name of Insurance Co.__________________________ID #________________________
Your Social Security#__________________________________

I hearby authorize payment of my insurance benefits to Koray Arin, O.D. I understand I am financially responsible for any charges, whether or not paid by my insurance. If co-payments and/or deductibles are designated by my insurance company, I agree to pay them to Koray Arin, O.D. I authorize Koray Arin O.D. to release any information required to process any & all claims for reimbursement on my behalf.

Signature____ Date_________________

I acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature____Date__________________