CASTLEMAN EYE CENTER
CHANGING LIVES THROUGH VISION

LASIK EXAM INFORMATION

Thank you for choosing Castleman Eye Center for your LASIK evaluation.

What to expect:

1. Your consultation with our ophthalmologist will last approximately 2 hours.
2. To perform a complete eye examination for LASIK, your eyes will be dilated. This causes light sensitivity and blurry near vision and may last for 24 hours.
3. If you are concerned about driving while dilated, please have a driver accompany you.
4. Bring your current eyeglasses (or prescription) with you, as well as sunglasses--we can provide sunglasses if needed.
5. LASIK fees vary based on your level of correction and will be determined during your appointment.

CONTACT LENS PATIENTS – IMPORTANT!!

If Your Contacts Are:	
Soft Contacts	Do not wear contacts for 3 days prior to exam
Hard Contacts/Rigid/Gas Permeable	Do not wear contacts for 3 full weeks prior to exam

LASIK PROCEDURE INFORMATION

- You and your doctor decide together which LASIK option is best for you.
- There are **2 steps involved** in LASIK procedures:
  - **Step 1 is Flap Creation** and can be done by a **blade or Laser**.
  - **Step 2 is reshaping your cornea** using the VISX S4 laser. The doctor uses a computerized map of your eye to perform this part of the treatment.
  - The vast majority of **LASIK patients see 20/20 or even better**!
- You are awake during the LASIK procedure, but you will be given a mild sedative pill to help you relax.
- **Your eyes will be numbed with drops. Aside from a little feeling of pressure, most likely you won't feel any pain during the procedure**.
- **Both eyes are treated at the same visit and most patients return to work the next day**.
- The **LASIK** procedure takes **less than 15 minutes.**

Appointment Date: _____ Time:_____

13080 Eureka Rd
Southgate MI 48195
1-800-403-0060

415 E. Maple Rd.
Troy MI 48083

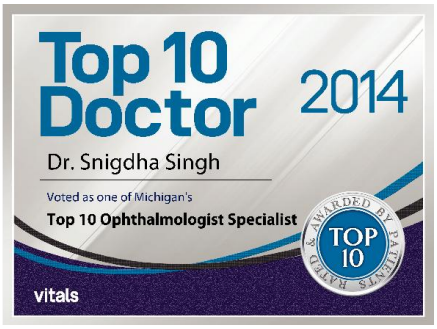
CASTLEMAN EYE CENTER
CHANGING LIVES THROUGH VISION

Snigdha Singh, M.D. **James R. Valice, M.D.**

Why Choose Castleman Eye Center for your LASIK procedure?

1. **We have our own dedicated State of the Art LASIK Operating Suite** in our Southgate office where we personally oversee the maintenance and safety of the equipment. There are some lasers that are transported from office to office on a daily basis. It is important to maintain temperature and humidity at all times for the laser to function properly.

2. **We have performed over 10,000 Laser Vision Correction Procedures** and have been in practice for over 40 years. **Dr. Singh received Vitals™ (a leading physician review site) Patient's Choice Award and Compassionate Doctor Recognition for 2012-2020, along with a 4 out of 4 Stars Rating.**



3. **We offer ALL LASER LASIK.** The LASIK flap is created with a LASER, not a blade. Eliminating the blade, gives you a **safer, more precise LASIK**. In fact, all branches of the U.S. Military only recommend this LASIK technology for their servicemen and women.

4. **We offer FREE Consultations and No money down, ZERO INTEREST FINANCING** for 2 Years through Care Credit.

5. **All inclusive pricing, no hidden fees**. Our fees include pre-op testing, surgery and post-op care for one year. Owning our laser enables us to offer very competitive pricing.

6. **Our surgeon, Dr. Singh, is a board certified, licensed ophthalmologist**, with over 20 years experience.

7. **Our VISX certified, surgical support staff** each have over 10 years experience assisting doctors in thousands of LASIK surgery procedures.

8. **All pre-op and post-op care is provided by your surgeon**, not ancillary staff.

9. **We are conservative with our recommendations**. We won't perform the LASIK procedure if we don't think you will achieve excellent results.

10. **We offer many discount programs**. Visit our website at www.castlemaneyecenter.com for more information.

11. **Our surgery center was named one of the 100 Best Places to Work** in Healthcare by Becker's ASC Review.

13080 Eureka Rd
Southgate MI 48195
Tel: (734) 283-0500
Fax: (734) 283-2720

415 E. Maple Rd.
Troy, MI 48083
Tel: (248) 813-0099

Demographics Form

PATIENT NAME			HOME PHONE#	WORK PHONE#
CELL PHONE#			EMAIL	
ADDRESS			CITY	STATE MI / ZIP
SEX	AGE	BIRTH DATE	MARITAL STATUS S M D W	SOCIAL SECURITY NUMBER

NOTE: The information below is a reporting requirement of the government Patient Protection and Affordable Care Act 2010. We are obligated to obtain this information from our patients.

Race □ White □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander	**Ethnicity:** □ Hispanic □ Not Hispanic **Language Preference:** □ English □ Other
EMPLOYER	**OCCUPATION**
SPOUSE NAME	**SPOUSE'S EMPLOYER**
EMERGENCY CONTACT: (For office use only: remember to add to Practice Partner) **NAME:**	**PHONE:**

MEDICAL INSURANCE INFORMATION

Primary:	***Subscriber Name/Birthdate:***
Secondary:	***Subscriber Name/Birthdate:***
Tertiary:	***Subscriber Name/Birthdate:***

VISION INSURANCE

Primary	**Secondary**
How were you referred to us? □ Patient/Family □ Google □ Internet □ Insurance □ Location □ Family Doctor □ Other_____	**If referred by Doctor please add information here:** **Name:** **Address:** **City:** **Phone:**
Family Doctor:	**Address:** **City:** **Zip:** **Phone:**
Pharmacy Name:	**Address:** **City:** **Zip:** **Phone:**

Medical History Questionnaire

Patient Name:_____ **Date of Birth:**_____

Email:_____ **Cell Phone:**_____

Allergies (drug, food or substance) & Reaction Severity

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

Past Ocular History: (Please mark all that apply)

□ **No History of Eye Disease**
□ Amblyopia (Lazy eye)
□ Aphakia
□ Astigmatism
□ Cataracts
□ Diabetic Retinopathy
□ Dry Eyes
□ Glaucoma
□ Hyperopia (Far sighted)
□ Iritis
□ Keratoconus
□ Macular Degeneration
□ Myopia (Near sighted)
□ Optic Neuritis
□ Retinal Detachment

Other_____

Eye Surgeries: (Please mark all that apply & list dates)

□ **No Prior Eye Surgery**
□ Blepharoplasty
□ Cataract Surgery_____
□ Corneal Transplant _____
□ Foreign Body Removal
□ Retinal Laser Surgery
□ LASIK _____
□ PRK
□ Glaucoma laser surgery
□ Punctal Plugs
□ RK
□ Strabismus Surgery (eye muscle surgery)
□ Trabeculectomy (Glaucoma surgery)
□ Vitrectomy/Retina Surgery

Other_____

Current Eye Drops (if any): (Please list)

_____

Medical Illnesses (if yes, indicate # of years):

□ **Overall Healthy**
□ Anemia
□ Arthritis
□ Arrhythmia
□ Asthma
□ Bleeding Disorder
□ Cancer
□ Thyroid Disease
□ Herpes/Shingles
□ Toxoplasmosis
□ Congestive Heart Failure
□ COPD
□ Diabetes _____yrs
□ Eczema
□ Fibromyalgia
□ Headache
□ Hearing Loss
□ AIDS/HIV positive
□ Sjogrens
□ Hepatitis A B or C
□ High Blood Pressure _____yrs
□ High Cholesterol
□ Graves Disease
□ Kidney Disease
□ Kidney Stones
□ Liver Disease
□ Lupus
□ Rheumatoid Arthritis
□ Lung Disease
□ Histoplasmosis
□ Migraine
□ Polymyalgia
□ Psychiatric Disorder
□ Skin Cancer
□ Stroke
□ Mult. Sclerosis(MS)

Insulin? Yes_____ No_____ Plaquenil for Rheumatoid Arthritis? Yes_____ No_____

General Surgeries / Operations: (Please list all & dates)

_____

_____

Current Medications: (Please list, including vitamins, supplements)

MEDICATION NAME	DOSE/MG.	HOW MANY PILLS & TIMES PER DAY
EXAMPLE:	*500 MG*	*1 PILL PER DAY*

---Turn over for page 2---

MEDICATIONS CONTINUED:

MEDICATION NAME	DOSE/MG.	HOW MANY PILLS & TIMES PER DAY

Family History (Mother, Father, Siblings, Grandparents):

□ Diabetes □ Stroke □ Blindness □ Macular Degeneration □ Arthritis
□ Cancer □ TB □ Cataracts □ Retinal Disease □ Lazy Eye
□ Heart Disease □ Kidney Disease □ Glaucoma □ High Blood Pressure

Other_____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No If yes how much and how often?_____

Drug Use: □ Yes □ No If yes what and how often?_____

Review of Systems: (Please mark all that apply):

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Constitutional
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitis

Genito-Urinary
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Psychiatric
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes

Blood / Lymphnodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

MusculoSkeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure