



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

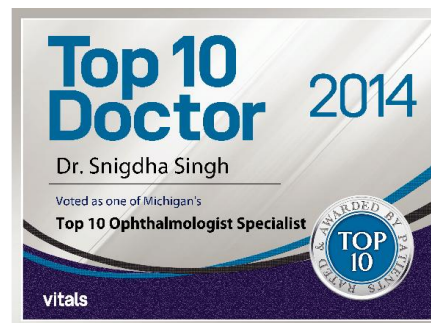


Snigdha Singh, M.D.

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	
<i>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.</i>						
Race <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander			Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic Language Preference: <input type="checkbox"/> English <input type="checkbox"/> 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? <input type="checkbox"/> Patient/Family <input type="checkbox"/> Google <input type="checkbox"/> Internet <input type="checkbox"/> Insurance <input type="checkbox"/> Location <input type="checkbox"/> Family Doctor <input type="checkbox"/> Other _____			If referred by Doctor please add information here: Name: Address: Phone:			
Family Doctor:			City: Zip: Phone:			
Pharmacy Name:			Address: City: Zip: Phone:			

Medical History Questionnaire

Patient Name: _____

Date of Birth: _____

Allergies (drug, food or substance) & Reaction Severity

_____ mild / moderate / severe
_____ mild / moderate / severe

Past Ocular History: (Please mark all that apply)

- | | | | |
|-----------------------------------------------------------|-----------------------------------------------|--------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> No History of Eye Disease | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hyperopia (Far sighted) | <input type="checkbox"/> Myopia (Near sighted) |
| <input type="checkbox"/> Amblyopia (Lazy eye) | <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Iritis | <input type="checkbox"/> Optic Neuritis |
| <input type="checkbox"/> Aphakia | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Keratoconus | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Astigmatism | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Macular Degeneration | |

Other _____

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

- | | | | |
|------------------------------------------------------|------------------------------------------------|-------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> No Prior Eye Surgery | <input type="checkbox"/> Foreign Body Removal | <input type="checkbox"/> Glaucoma laser surgery | <input type="checkbox"/> Trabeculectomy |
| <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> Retinal Laser Surgery | <input type="checkbox"/> Punctal Plugs | (Glaucoma surgery) |
| <input type="checkbox"/> Cataract Surgery _____ | <input type="checkbox"/> LASIK _____ | <input type="checkbox"/> RK | <input type="checkbox"/> Vitrectomy/Retina Surgery |
| <input type="checkbox"/> Corneal Transplant _____ | <input type="checkbox"/> PRK | <input type="checkbox"/> Strabismus Surgery | (eye muscle surgery) |

Other _____

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

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

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

Insulin? Yes _____ No _____

Plaquenil for Rheumatoid Arthritis? Yes _____ No _____

Other _____

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

Current Medications: (Please list)

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):

<p>Eyes</p> <ul style="list-style-type: none"> <input type="checkbox"/> Previous Surgery <input type="checkbox"/> Contact Lens <input type="checkbox"/> Pain <input type="checkbox"/> Double Vision <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Dry Eyes <input type="checkbox"/> Flashes <input type="checkbox"/> Floaters <p>Ear, Nose, and Throat</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Vertigo <p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting Spells <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Difficulty Lying Flat <p>Constitutional</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fatigue / Weakness <input type="checkbox"/> Fever <input type="checkbox"/> Weight Gain / Loss 	<p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cough <input type="checkbox"/> Congestion <input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma <p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Jaundice / Hepatitis <p>Genito-Urinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain / Difficulty <input type="checkbox"/> Blood in Urine <input type="checkbox"/> History of Kidney Stones <input type="checkbox"/> History of STD's <p>Psychiatric</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety / Depression <input type="checkbox"/> Mood Swings <input type="checkbox"/> Difficulty Sleeping <p>Endocrine</p> <ul style="list-style-type: none"> <input type="checkbox"/> Increased Thirst <input type="checkbox"/> Increased Hunger <input type="checkbox"/> Increased Urination <input type="checkbox"/> Increased Sweating <input type="checkbox"/> Fingernail Changes 	<p>Blood / Lymphnodes</p> <ul style="list-style-type: none"> <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Gums Bleed Easy <input type="checkbox"/> Prolonged Bleeding <input type="checkbox"/> Heavy Aspirin Use <p>MusculoSkeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Stiffness <input type="checkbox"/> Arthritis <input type="checkbox"/> Joint Pain / Swelling <p>Skin</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rash / Sores <input type="checkbox"/> Lesions <input type="checkbox"/> Hives / Eczema <p>Neurological</p> <ul style="list-style-type: none"> <input type="checkbox"/> Seizures <input type="checkbox"/> Weakness / Paralysis <input type="checkbox"/> Numbness <input type="checkbox"/> Tremors <p>Immunologic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Runny Nose <input type="checkbox"/> Sinus Pressure
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Dry Eye Survey

- _____ **Fluctuation in vision** _____ **Redness** _____ **Film over vision** _____ **Burning**
- _____ **Tired Eyes** _____ **Watery Eyes** _____ **Feeling of sand or grit in eye(s)**