Your Information

Personal Details

Title **Mr** **Mrs** **Miss** **Ms**

First name

Second name

Address

Post code

Date of birth / /

Home telephone

Work Tel

Mobile

Email

Next of Kin

Name

Contact No

Relationship

How did you find out about us?

Was it a Referral? If so who? (Please circle below)

Friend **GP** **Optician** **Other**

Name

Your Information

From the Internet? If so where? (Please circle below)
Website **Google** **Other sites**

Other ....

Adverts in (please circle below)
Magazines **Newspapers** **Other**

Other ....

Doctors Details

General Practitioner

Full name

....

Clinic

....

Address

....

....

....

Post code ....

Telephone: ....

Other specialist / optician

Full name

....

Clinic

....

Address

....

....

....

Telephone ....

Speciality ....

Your Information

CENTRE FOR SIGHT

Reason for Consultation?

Why do you want a consultation with us? What do you want to achieve? What procedure are you interested in?

....

....

....

....

Activities, vision and contact lenses

Activities

What is your occupation?

....

Does it involve night driving?

....

What sports do you engage in?

....

How many hours a day do you use a computer/tablet/phone?

Your visual needs

Please help us evaluate your visual needs. Mark on the scales the weight of importance (e.g. amount of time spent and of personal values) in the following day to day activities (0 being of importance and 10 being very important):

Reading

1 2 3 4 5 6 7 8 9 10

Using computers

1 2 3 4 5 6 7 8 9 10

Driving

1 2 3 4 5 6 7 8 9 10

Driving at night

1 2 3 4 5 6 7 8 9 10

Your Information

CENTRE FOR SIGHT

Contact lenses

Do you wear contact lenses?

....

If yes, what type?

....

How long has your lenses been out prior to consultation?

....

Allergies and Medication

Allergies

Do you have allergies?

- ☐ Yes
- ☐ No

If yes, please specify

....

....

Do you take any eye medication?

Please list the medications that you are on and how often you are taking them. Please answer as best as you can:

Medication ....

Dose ....

How often ....

Medication ....

Dose ....

How often ....

Medication ....

Dose ....

How often ....

Your Information

Do you take any eye medication?

Please list the medications that you are on and how often you are taking them. Please answer as best as you can:

Medication ....

Dose ....

How often ....

Medication ....

Dose ....

How often ....

Medication ....

Dose ....

How often ....

Office use only

Name: ....

DOB: ..../............/............

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Your Medical History

CENTRE FOR SIGHT

Personal Details

Title **Mr** **Mrs** **Miss** **Ms**

First name

....

Second name

....

Date of birth

.... / .... / ....

Medical History

Do you have:	Yes	No	and for how long?
Asthma	☐	☐	....
Diabetes	☐	☐	....
Eczema	☐	☐	....
Hay Fever	☐	☐	....
Heart Disease	☐	☐	....
High blood pressure	☐	☐	....

Other medical conditions

....

....

Have you ever had any operations?

If the answer is **yes** please tell us more:

Eye operation ....

When ....

Where ....

Eye operation ....

When ....

Where ....

Eye operation ....

When ....

Where ....

Your Medical History

Is there anything else you feel we should know, or do you have any other comments?

....

....

....

....

....

Family History

Does anyone in your family have:

	Yes	No	who (relationship to you)
Glaucoma	☐	☐	....
Diabetes	☐	☐	....

Are there any other medical conditions in your family? Please explain:

....

....

....

....

....

....

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DOB: ..../................/................

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Patient Agreement

Guarantor

Who will be responsible for costs?

Self ☐
Parent ☐
Other ☐

If other, please specify:

....

....

Medical insurance details

Do you have medical insurance? **Yes** / **No**

If **yes,** please provide the following insurance details:

Company name ....

Policy/membership number ....

Photography

At Centre for Sight, to ensure high quality care is maintained, our standard is as far possible to video all procedures. This acts as both a record of the procedure and an audit of what has taken place. Please initial below that you have understood. If you object to a photographic or video record, please indicate this to Centre for Sight staff who will place the information on your record.

Please Initial here ....

Consent to obtain and release information

Please initial to confirm that you consent to mutual communication of your medical notes between Centre for Sight and your GP, Optician or other allied health care professional.

Please Initial here ....

Patient Agreement

Declaration

Mr Sheraz M. Daya, Medical Director has financial interests in the Centre for Sight and the McIndoe Surgical Centre. Mr Daya is also a consultant for Bausch and Lomb, manufacturer of ophthalmic equipment.

Non Insured Patients

I am responsible for all fees and agree to settle my account directly with Centre for Sight or its consultants as appropriate and fees will be payable at the time of consultation.

Signed: ....

Date: ....

Insured Patients

I understand that I must pay for consultations, tests and investigations at the time of my appointment. I permit Centre for Sight and/or its consultants to make a claim against my insurance company for any surgical procedures, but agree to obtain pre-authorisation/approval in advance of surgery and forward a copy of this to Centre for Sight. I understand the invoices for my procedure will be submitted on my behalf for the surgeons fee and by Centre for Sight for the hospital fee. The anesthetist (if present) will submit a separate invoice directly to your insurance provider. I am aware that there may be a shortfall between the fees charged and the amount settled by my insurance provider. If this is the case my insurance provider will advise me in writing of my liability.

Signed: ....

Date: ....

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Office use only

Name: ....

DOB: ..../................/..................

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