S I G H T L I N E
Laser Eye Center & Ophthalmic Associates
2591 WEXFORD-BAYNE ROAD, SUITE 104 SEWICKLEY, PA 15143 P (724) 933-5588 F (724) 933-6051

Welcome to our office!

We are honored that your doctor has selected us to participate in your care. Our role is to deliver excellent patient care and to meet the high expectations of you and your doctor. Your doctor is in a unique position to be able to evaluate our services. This is a strong motivating force for us and should be a source of comfort for you.

If you wear contact lenses, please leave them out prior to your appointment:

- Soft lenses: 3 days
- Soft toric (astigmatism-correcting) lenses: 1 week
- Gas permeable lenses: Your eye doctor should stabilize your cornea first. This time period varies.

Depending on testing done by your doctor, you may be dilated for your evaluation. If you are comfortable driving after dilation, a driver is not required. If you feel unsafe driving after dilation, please plan to have a driver with you. You must have a driver with you the day of your surgery. Please plan to be at the office for 2 hours for your procedure.

Please complete both sides of the **HEALTH HISTORY FORM** prior to your visit. This will shorten your time in the office. If you have any trouble completing this information, someone from our office will be happy to help you at the time of your visit. Please bring your forms and your **MEDICAL INSURANCE CARD(S)** with you to your appointment.

Do not hesitate to call our office if you have any questions. We look forward to meeting you!

Sincerely,

The SightLine Doctors & Staff

HEALTH HISTORY

Patient Information

Patient Name _____ D.O.B. _____/_____/_____

Address _____ City_____

State _____ Zip Code _____ Social Security #_____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Employer _____ Occupation _____

Emergency Contact Name _____ Relation _____

Emergency Contact Phone _____ Eye Doctor _____

Family Doctor _____ Family Doctor Phone _____

Preferred Pharmacy _____ Phone/Location _____

Social History

Does your vision limit any activities of daily living? (please check)

☐ driving ☐ reading ☐ sports ☐ work ☐ other _____

Do you drink alcohol? No / Yes How often? _____

Do you smoke? No / Yes How much? _____ For how many years? _____

☐ Cessation of Smoking Intervention given to patient

Family History

Is there any family history of the following? (please circle) If yes, list family member:

Blindness No / Yes _____ Cataract No / Yes _____

Glaucoma No / Yes _____ Diabetes No / Yes _____

Macular Degeneration No / Yes _____

Past Visual & Medical History

Have you ever had any eye injuries or surgeries? ☐ No ☐ Yes If yes, please list them and the approximate year:

_____

Have you ever had any other surgeries? ☐ No ☐ Yes If yes, please list them and the approximate year:

_____

Do you have any history of cancer? ☐ No ☐ Yes If yes, please explain:

_____

NAME_______________________________________

Please list any medications and why you are taking them:

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Are you, or have you ever, taken the following medications:
Flomax (tamsulosin), Hytrin (terazosin) or Minipress (prazosin)? ☐ No ☐ Yes

Ozempic (semaglutide), Trulicity (dulaglutide) or Mounjaro (tirzepatide)? ☐ No ☐ Yes

Are you allergic to any latex products? ☐ No ☐ Yes

Are you allergic to any medications? ☐ No ☐ Yes, please list: ______________________________

Do you use oxygen? ☐ No ☐ Yes, only at night ☐ Yes, all the time

Please check any boxes that apply to conditions that you currently have or have had in the past:

Allergic/Immunologic
- ☐ drug allergy
- ☐ environmental allergy
- ☐ other allergy
- ☐ rheumatoid arthritis
- ☐ lupus
- ☐ other _______________
- ☐ **NONE**

Lungs/Breathing
- ☐ cigarette smoker
- ☐ asthma
- ☐ bronchitis
- ☐ COPD
- ☐ emphysema
- ☐ sleep apnea CPAP: Y N
- ☐ other _______________
- ☐ **NONE**

Endocrine
- ☐ non-insulin diabetic
- ☐ insulin diabetic
- ☐ thyroid dysfunction
- ☐ hormonal dysfunction
- ☐ pregnant/breastfeeding
- ☐ other ______________
- ☐ **NONE**

Eyes
- ☐ glaucoma
- ☐ cataracts
- ☐ macular degeneration
- ☐ inflammatory disorders
- ☐ previous surgery
- ☐ other ______________
- ☐ **NONE**

Gastrointestinal
- ☐ Crohn's
- ☐ colitis
- ☐ ulcer
- ☐ digestive problems
- ☐ other ______________
- ☐ **NONE**

Cardiovascular
- ☐ heart disease
- ☐ defibrillator
- ☐ high blood pressure
- ☐ stroke
- ☐ poor circulation
- ☐ high cholesterol
- ☐ other _______________
- ☐ **NONE**

Musculoskeletal
- ☐ arthritis
- ☐ muscular dystrophy
- ☐ fibromyalgia
- ☐ ankylosing spondylitis
- ☐ other ______________
- ☐ **NONE**

Genitourinary
- ☐ STD
- ☐ urinary problems
- ☐ prostate problems
- ☐ other _______________
- ☐ **NONE**

Neurological
- ☐ multiple sclerosis
- ☐ epilepsy
- ☐ other ______________
- ☐ **NONE**

Skin
- ☐ eczema
- ☐ rosacea
- ☐ psoriasis
- ☐ other ______________
- ☐ **NONE**

Constitutional
- ☐ developmental disability
- ☐ sudden weight loss
- ☐ fatigue
- ☐ trauma
- ☐ other ________________
- ☐ **NONE**

Psychiatric
- ☐ depression / anxiety
- ☐ panic disorder
- ☐ schizophrenia
- ☐ dementia/Alzheimer's
- ☐ other _______________
- ☐ **NONE**

Blood/ Lymphatic
- ☐ leukemia
- ☐ anemia
- ☐ large volume blood loss
- ☐ other ________________
- ☐ **NONE**

Ear, Nose, Throat
- ☐ upper respiratory tract infection
- ☐ other ______________
- ☐ **NONE**

CURRENT: HEIGHT _____ ft. _____ in. WEIGHT ______ lbs.

For Office Use Only

Medical History Updates: Date: ______________ Tech Initials: _____________ Doctor Initials: ____________

Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:
Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:
Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:	Date: Changes made? Yes No Tech Initials: Doctor Initials:
			BMI _______

SightLine Laser and Ophthalmic Associates
ADVANCE NOTICE & ACKNOWLEDGEMENT OF POLICIES

HIPAA PRIVACY POLICY

A copy of our Notice of Privacy Practices is posted at the front desk and can be found in our 'Privacy Binder'. You have the right to have a copy of this policy. Please see a staff member to request a copy of our HIPAA policy for your records. Signing below acknowledges that you have had the opportunity to review the Notice of Privacy Practices and have been offered a copy.

REFRACTIONS

A refraction may be performed at your evaluation and/or subsequent follow-up visits. This is a test to determine the best possible vision. This test is a separate component to the medical exam and is NOT COVERED BY INSURANCE PLANS. Our current fee for this service is $45.00. If you choose to pay for the refraction on the day of service, a $10 cash discount will be extended.

ASSIGNMENT OF BENEFITS

Signing below authorizes and directs your insurance carrier(s), including Medicare and private insurance plans, to issue payment check(s) directly to SightLine Ophthalmic Associates for medical services rendered to you and/or your dependents. You also authorize the release of any information needed to determine benefits and submit claims for these services.

FINANCIAL RESPONSIBILITY

Fees (including co-pays) are due and payable on the date that services are rendered. You have requested medical services from SightLine Ophthalmic Associates, and by making this request, you become fully financially responsible for any and all charges (including co-insurance, deductibles and non-covered services) incurred in the course of the treatment authorized.

By signing below, I am confirming that I have read and understand this notice and confirm that I have been given the opportunity to ask whatever questions that I might have and that they have been answered to my satisfaction.

_____
Patient Name (print)

_____ _____
Signature Date