



The term “cataract” refers to a cloudy lens within the eye. When a cataract is removed, a lens implant is placed inside the eye to replace the cloudy human lens. Occasionally, clear lenses that have not yet developed cataracts are also removed to reduce or eliminate the need for glasses. If it is determined that lens replacement is appropriate, your answers will help us provide the best vision possible so you can enjoy activities most important to you.

**1** If lens replacement is recommended for you, please rate your vision preferences at the following distances?

**Distance Vision:** driving, golf, tennis, other sports, watching TV.

- Prefer no distance glasses
- I wouldn't mind wearing distance glasses

**Mid-range Vision:** computer, menus, price tags, cooking, board games, items on a shelf.

- Prefer no mid-range glasses
- I wouldn't mind wearing mid-range glasses

**Near Vision:** reading books, newspapers, magazines, doing detailed handwork.

- Prefer no near glasses
- I wouldn't mind wearing near glasses

**2** Please check the single statement that best describes you in terms of **night vision:**

- Night vision is extremely important to me, and I require the best possible quality.
- I want to be able to drive comfortably at night, but I would tolerate some slight imperfections.
- Night vision is not important to me.

**3** If you **had to wear glasses after surgery for one activity**, for which activity would you be most willing to use glasses?

- Distance Vision
- Mid-Range Vision
- Near Vision

**4** If you could have good distance vision during the day without glasses, and good near vision for reading without glasses, but the compromise was that you **might see rings or starbursts** around lights at night, would that be OK?

- Yes
- No

**5** If you could have good distance vision and mid-range vision during the day and at night without glasses, but the compromise was that you **might need glasses for reading** the finest print at near, would you like that option?

- Yes
- No

**6** How many hours per day do you spend:

\_\_\_\_\_ **On the computer**

\_\_\_\_\_ **Reading** books, newspapers, typed documents or small print

\_\_\_\_\_ **Driving**

**7** List your favorite **hobbies or work** activities.

**8** Please place an “X” on the scale to **describe your personality** as best you can:

\_\_\_\_\_  \_\_\_\_\_   
**Easy going** **Perfectionist**



## REGISTRATION FORM

Today's Date: \_\_\_\_\_

<b>Name</b>		<b>Date of Birth</b>		<b>Gender</b>
<b>Address</b>		<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Best Phone</b>	Is this: Cell Home Work		<b>SSN</b>	
<b>Best Email</b>		<b>Employer</b>		
<b>Name of Insured</b>			<b>Relationship</b>	
<b>Emergency Contact</b>			<b>Phone</b>	
<b>Primary Care Doctor</b>		<b>Optometrist</b>		
<b>Pharmacy</b>		<b>City</b>	<b>Phone</b>	

**ASSIGNMENT OF BENEFITS:** I request that payment of authorized benefits be made either to me or on my behalf to Hayden Vision for services furnished to me by Hayden Vision providers. I authorize any holder of medical information about me be released to the insurer and its agents as needed to determine benefits payable for related services.

**RELEASE OF INFORMATION:** Hayden Vision may disclose all or any part of my medical record and/or financial ledger including alcohol or drug abuse, psychiatric illness, communicable disease, or HIV to any person or corporation 1) which is or may be liable or under contract to Hayden Vision for reimbursement of services rendered; 2) any healthcare provider for continued patient care; 3) Family members unless otherwise indicated by the patient. **DO NOT release medical information to:** \_\_\_\_\_

**FINANCIAL AGREEMENT:** I agree that in return for services provided by Hayden Vision, I will pay any amount my insurance does not cover, including deductibles and/or co-payments at the time that services are rendered, or I will make arrangements that day satisfactory to Hayden Vision. If my account is sent to a collection agency, I agree to pay reasonable collection expenses. It is understood that the undersigned and/or patient are primarily responsible for payment of my bill.

**SELF PAY PATIENTS:** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Send an itemized receipt with your claim to your insurance carrier who will reimburse you directly.

**NON-COVERED SERVICES:** I understand that Hayden Vision contracts with healthcare service plans for services covered by these plans. Accordingly, the undersigned accepts full financial responsibility for all items or services.

**CO-PAYMENTS:** By law we must collect your co-pay at the time of service. Please be prepared to pay this copay at each visit.

**REFRACTIONS:** A refraction fee of \$45.00 is the responsibility of the patient. Insurance considers this a non-medical charge and therefore it is not covered under private insurance, Medicare, or Medicaid benefits.

**Signature of Patient or Insured:** \_\_\_\_\_



**HEALTH HISTORY**  
New Patient

NAME \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

OCULAR HISTORY		YES	NO			YES	NO			YES	NO
Allergic Conjunctivitis				Glaucoma				Retinal Tear			
Blepharitis				Macular Degeneration				Retinal Detachment			
Cataract				Macular Pucker				Strabismus (Lazy Eye)			
Fuchs Corneal Dystrophy				Narrow Angles				Vitreous Detachment			
Diabetic Retinopathy				High Eye Pressure				Other?			
Dry Eyes				Ocular Migraine							

OCULAR SURGERY		R	L			R	L			R	L
Cataract Surgery				Glaucoma Laser				Retinal Tear			
Corneal Transplant				Eyelid Surgery				Retinal Detachment			
Eye Muscle Surgery				Punctal Plugs				Strabismus (Lazy Eye)			
Eye Injections				Strabismus Surgery				Vitreous Detachment			
LASIK				Retinal Laser				Other?			
PRK				Trabeculectomy							

FAMILY HISTORY		YES	NO	FAMILY MEMBER?		YES	NO	FAMILY MEMBER?			
Blindness								Retinal Detachment			
Glaucoma								Macular Degeneration			

SOCIAL HISTORY				
Cigarettes	Never	Quit	Occasional	Daily
Alcohol	None	Less than daily	1-2 drinks per day	3+ drinks per day
Occupation				

**Please turn page over**

<b>MEDICAL HISTORY</b>	
Medications (list here or provide us a list):	Allergies (list or write "none"):
Significant medical conditions? (list)	Significant surgeries? (list)

<b>RECENT CHANGE IN OVERALL HEALTH</b>	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
Fever			Active seasonal allergies		
Uncontrolled blood sugar			Arthritis flare-up		
Chest pain			Depression		
Numbness or burning in feet			Anxiety		
Chemotherapy or radiation treatments			COVID		

How did you hear about our practice? \_\_\_\_\_