LaserVue
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www.laservueorlando.com

Thank you for considering us for your refractive care needs. We would like to ensure that your visit is enjoyable and efficient. Kindly fill out the enclosed information forms prior to your arrival.

During your visit you will see Dr. Magruder . We will perform several tests to help determine both your candidacy for refractive surgery and what the best procedure is for you. This process takes time; plan on one hour at least for the testing and consultation. We request that you wear glasses to your first consultation appointment. If you do need to wear contact lenses, please bring your written prescription or contact lens box.

Our refractive team looks forward to meeting you.

Sincerely,
The LaserVue staff

OUR MISSION

To continue our tradition of personalized care, combining our experience with the best technology to enrich our patients' lives.

Date________________________________

Dr. Mr. Mrs. Ms. ___________________________

Soc. Sec.#______________________________

Address____

Date of Birth_________________ Age______

City __________________________ Zip_______________

Home Phone____________________________

Occupation_______________________________________

Work Phone ___________________________

Spouse's Name____________________________________

Cell Phone ____________________________

Hobbies____

E-mail________________________________

How did you hear about us? Television Radio Newspaper Ad Internet Yellow Pages Other

Referred by Dr. _______________________
Mr. / Mrs. / Ms. _______________________ Did this person have Lasik here? Yes When? _____ No

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What are your goals for having refractive surgery? ____
____

Have you ever had any eye surgery? Yes No If yes, give type and date______________________________

Date of last eye exam ______________With whom? ___________________Age of present glasses ____________

Do you wear contact lenses? Yes No For how long? _____________________________________

I used to wear contacts, but I don't now because____

Type? Spherical soft Toric soft Hard/RGP Don't know

How many hours per day do you wear them? ______ Do you sleep in them? Yes No Monovision? Yes No

Have you stopped wearing contacts for the Lasik surgery? Yes No If yes, for how long? _______________

Check box if you HAVE HAD OR HAVE any of the following:

Cataracts	Ocular Herpes	Asthma	Currently Pregnant or Nursing
Glaucoma	Corneal Infection	Arthritis	Kidney Disease
Retinal Disease	Crossed Eyes	Diabetes	Multiple Sclerosis
Dry Eyes	Fibromyalgia	Hypertension	Chronic Fatigue Syndrome
Blepharitis	Keloids	Heart Disease	Any other Disease ____________________

List current medications _______________________________ Do you take: ___ Imitrex? ___ Acutane?
____

Check if you are allergic to Valium Xylocaine Any other medications___________________________

Name of nearest relative NOT living with you____________________________ Relationship_______________
Address ____ Phone_____________________

LIFETIME AUTHORIZATION

I request that payment of authorized Medicare or other insurance benefits be made either to me or on my behalf for any services furnished to me by the Doctors affiliated with the LaserVue/Eye Foundation. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration, its agents, or other insurance carriers, any information needed to determine these benefits for related services.

________________________ ____
Date Signature

LaserVue / Eye Foundation ** Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information
Please review carefully.

At LaserVue / Eye Foundation, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
We may use your information to contact you. For example, we may send newsletters or other information.
We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.
If this practice is sold, your information will become the property of the new owner.
Except as described above, this practice will not use or disclose your health information without your prior written authorization.
You may request in writing that we not use or disclose your health information as described above.
We will let you know if we can fulfill your request.
You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
You have the right to transfer copies of your health information to another practice. We will mail your files for you.
You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.
You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S. W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Bill Meyers at (407) 843-5665.
This notice goes into effect as of April 14, 2003.

Acknowledgement

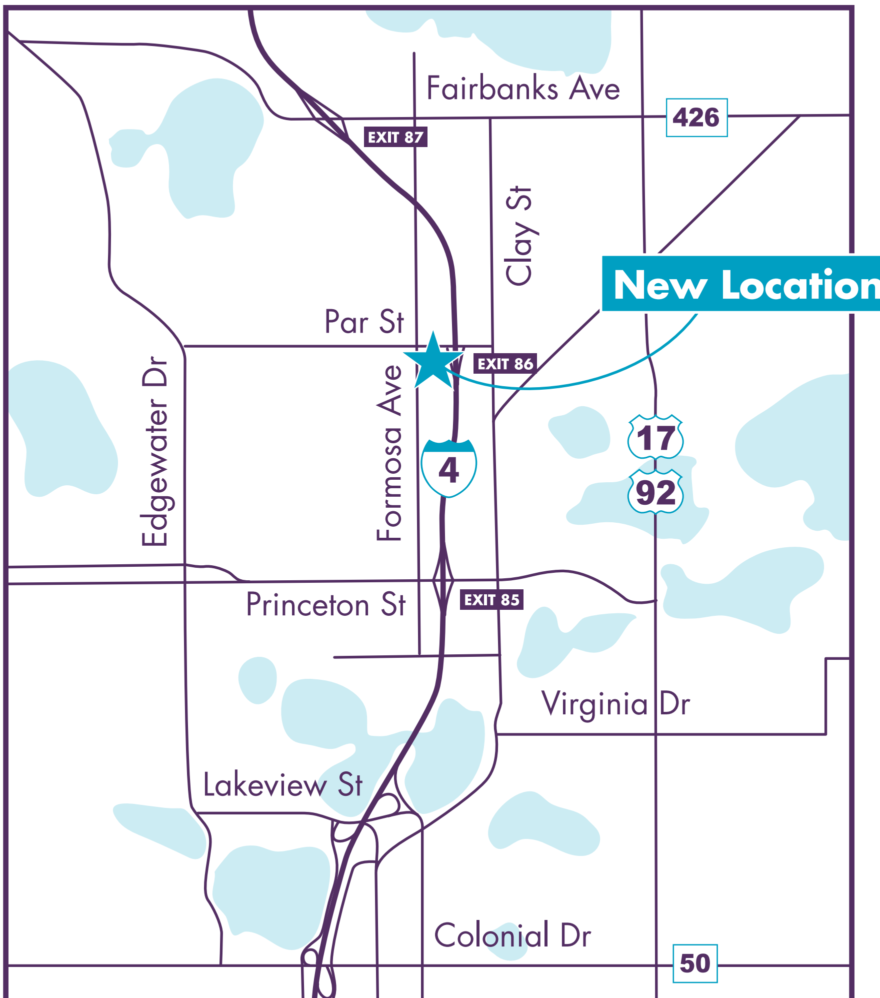
I have received a copy of the **LaserVue / Eye Foundation** Notice of Privacy Practices. Date_____________

Signed __________________________________ Print Name____

If signing as a parent or guardian, please note the name of the patient __________________________________

LaserVue

G. Brock Magruder Jr., M.D.



120 E Par Street, Suite 2000 • Orlando, FL 32804

Going West on I-4:
Exit 85, Princeton Street. Turn right. Take your next right onto Formosa. Go approximately 1 miles to the next light, turn right on Par Street. Building is on the right.

Going East on I-4:
Exit 86, Par Street. Turn left and go under the overpass. Building is immediately on the left.

Coming From East/West (408):
Exit I-4 East, got to Exit 86, Par Street. Turn left and go under the overpass. Building is immediately on the left.