Whiting Clinic
LASIK + EYE CARE

PERSONAL INFORMATION

First Name	Preferred Name	Middle Initial	Last Name

Street Address

City	State	Zip Code

Cell Phone	Home Phone	Work Phone

Email Address (will be used for internal purposes only such as confirming appointments)

Date of Birth	Age

Occupation

Hobbies (tell us how you use your eyes)

Who or what influenced you to contact Whiting Clinic? Please select the primary source only.

☐ Previous Whiting Clinic Patient Name: ________	☐ Previous Non-Whiting Clinic Patient Name: ________	☐ Other
☐ Radio Station: ________	☐ Website / Internet: ________	Please List:
☐ Mailer Type: ________	☐ Facebook Page: ________	________
☐ TV Program: ________	☐ Minnesota Wild	

Were you referred by your eye doctor? ☐ **YES** ☐ **NO**	If yes, Doctor's Name:

How long have you been considering Laser Vision Correction?

EMERGENCY CONTACT

Name of local relative or friend	Relationship	Phone Number

I understand that this complimentary evaluation is for laser vision correction purposes only and does not include a glasses or contact lens prescription. Testing may be recommended that is outside of the complimentary LASIK exam testing. If I choose to proceed with extra testing, Whiting Clinic can submit testing to my insurance and I understand payment is my responsibility.

Patient Signature	Date

Please continue to the next page.

Do you have or have you ever been treated for the following:

Patient Name:

Presently pregnant or nursing?	☐ **YES**	☐ **NO**
Herpes eye infections?	☐ **YES**	☐ **NO**
Taking Accutane (isotretinoin) for acne?	☐ **YES**	☐ **NO**
Taking Cordarone (amiodarone hydrochloride) for controlling normal heart rhythm?	☐ **YES**	☐ **NO**
Taking Imitrex?	☐ **YES**	☐ **NO**
Keratoconus (a corneal disease) or have another condition that causes thinning of your cornea?	☐ **YES**	☐ **NO**
Collagen, autoimmune, vascular, or immunodeficiency disease (such as Arthritis, Lupus, or HIV)?	☐ **YES**	☐ **NO**

About Your Eyes

When was your last eye exam?	Who is your current eye doctor/optometrist?

How old are your glasses?

Do you currently have trouble with bright lights?	☐ **YES**	☐ **NO**		
Do you currently have trouble with night vision?	☐ **YES**	☐ **NO**		
Have you ever had a corneal scratch or erosion?	☐ **YES**	☐ **NO**		
Have you been treated for dry eye?	☐ **YES**	☐ **NO**		
Do your glasses have prisms in them (to help with double vision)?	☐ **YES**	☐ **NO**		
Do you wear contact lenses?	☐ **YES**	☐ **NO**		
If yes, select type:	☐ **SOFT**	☐ **TORIC**	☐ **RGP**	☐ **HARD**
If yes, select use:	☐ **DAILY**	☐ **EXTENDED WEAR (sleep in)**		
How often do you replace your contacts?				
Have you ever had any surgery, injuries, or laser treatments to the eye?	☐ **YES**	☐ **NO**		
If yes, please list:				

Your Medical History

Do you have or have you ever been treated for the following (check all that apply):

☐ Stroke	☐ Liver Disease	☐ Other Blood Vessel Disorders	☐ Kidney Stones
☐ Seizure	☐ Cancer or Tumor	☐ High Blood Pressure	☐ Prostate Disease
☐ Stomach Disorder	☐ Autoimmune Disease	☐ History of Drug or Substance Abuse	☐ Kidney Infection
☐ Ulcer	☐ Emphysema	☐ Other Brain or Nerve Disorder	☐ Mental Health
☐ Heart Disease	☐ Bypass Surgery	☐ Pneumonia	☐ Digestive Disease
☐ Brain Tumor	☐ Hepatitis B or C	☐ Arthritis	☐ Other:
☐ Nephritis	☐ Asthma	☐ Keloids	______________

Are you diabetic?	☐ **YES**	☐ **NO**	If yes: how long?
Do you currently use insulin?	☐ **YES**	☐ **NO**	Last HbA1C test:

List all medications you are ALLERGIC to:

List all medications and dosages you are CURRENTLY taking, including over the counter medications:

List all surgeries you have had:

In your immediate family (parents/siblings) is there any history of:

☐ Cataracts ☐ Glaucoma ☐ Lazy Eye ☐ Diabetes ☐ Blindness ☐ Retinal Disease

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Patient HIPAA Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the user or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you, should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to consent in this document, at some future time, you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice. However, we are not obligated to alter internal policies to conform to your request.

PRINT NAME: ______________________________

SIGNATURE: ______________________________ **DATE:** ______________

Mass Media Authorization

I hereby give permission for the use of any video or written testimonial that I willingly record or write, including but not limited to communication via social media resources.

INITIAL: ______________________________ **DATE:** ______________

Advanced Avellino DNA Testing

The Avellino DNA Duel Test is a screening test for a genetic corneal disease called Granular Corneal Dystrophy Type 1 and 2 (GCD), a rare condition that causes gradual clouding of the cornea and visual loss in the middle adult years or later (usually 6th or 7th decade).

LASIK doesn't cause GCD but any corneal interference (surgery or injury) might worsen the condition if done on someone with the genetic disease, usually 1-9 years after the incident.

Whiting Clinic is the only clinic in the US to have screened all LASIK patients for GCD for an extended period of time (solely at the cost to the clinic). The prevalence of GCD is very low and the actual incidence in MN remains unknown. Studies have shown higher indigence in Korean and Japanese subpopulations, but GCD has been found in Caucasians as well.

Only in the past couple of years has testing for the gene associated with GCD been clinically available in the US.

WHAT YOU SHOULD KNOW:

1) To date, neither Whiting Clinic nor Dr. Whiting has knowingly had a LASIK patient develop GCD, though it could happen years later.

2) The prevalence of the genetic marker is very low in our geographic community – at this point "0%" in over 1700 screening tests conducted at Whiting Clinic.

3) Individuals with a family history of GCD should be tested before having LASIK.

4) Individuals of Korean or Japanese decent should strongly consider testing before LASIK.

The likelihood of GCD is low enough that routine screening has not become a "community standard" for determining LASIK candidacy. However, if you would like to be tested before having LASIK, Whiting Clinic will perform the test for a subsidized cost of $50 to make it affordable to you.

You may opt-out of testing by signing below:

Patient Signature ______________________________________ Date____________________