Clemson Eye

Toll-Free: 855-654-2020
Web: clemsoneye.com

Dear Patient,

Welcome and thank you for choosing Clemson Eye, a leader in advanced eye surgery. Our eye surgeons are all American Board Certified Ophthalmologists and have together performed over 100,000 cataract and microsurgical procedures. Modern cataract surgery is a pain-less, stitch-less, fast procedure with almost immediate recovery.

While we perform both laser and traditional cataract surgery, laser cataract surgery with advanced lens implants can dramatically improve your post-operative eyesight, regardless of your age. Recent advances in technology allow us to achieve things in cataract surgery we wouldn't have dreamed possible a few short years ago. Please read the enclosed brochure carefully and pay close attention to the information about preparing for your exam.

Please complete the enclosed forms and give them to the receptionist when you arrive

Also, bring with you:

- Eye glasses and/or contact lenses you currently use
- Medical and/or Vision Plan Insurance cards (including primary policy holder information)
- Referral letter, if required by your insurance
- Photo identification
- Form of Payment
- List of Medications

A cataract exam is extensive and takes about 2 to 3 hours. If you have time restrictions, please let us know prior to your appointment. Your eyes will be thoroughly examined by the doctor, and several diagnostic tests will be performed. You are encouraged to bring a friend/family member with you. Throughout this evaluation, we will determine if you are a candidate for a cataract procedure, if you are ready, then you will leave us knowledgeable and prepared for the operation. Your pupils may be dilated, causing temporary blurriness and light sensitivity that can last for several hours. Please exercise caution if you are driving and wear sunglasses or have someone transport you.

Upon completion of your exam, covered charges for our services will be billed directly to your medical insurance provider. You will be responsible for paying for any co-pays, co-insurance, deductibles, and non-covered services. You will meet with a cataract counselor who will explain all aspects of the financial situation before any final decisions are made. We accept cash, check and credit cards. Payment plans are available for higher balances. We look forward to serving you soon!

Your Clemson Eye Family

Anderson Clinic – Greenville
2011 East Greenville St
Anderson, SC 29621

Anderson Clinic – Fant St
1220 N Fant St
Anderson, SC 29621

Clemson Clinic
931 Tiger Blvd
Clemson, SC 29631

Clinton / Laurens
22995 U.S. 76
Clinton, SC 29325

Easley Clinic
15 Southern Center Court
Easley, SC 29642

Greenville – Halton Green Way
One, Halton Green Way,
Greenville, SC 29607

Greenville Clinic – Pelham
360 Pelham Road
Greenville, SC 29615

Newberry Clinic
2735 Winnsboro Rd.,
Newberry, SC 29108

Powdersville Clinic
3529 Hwy 153
Greenville, SC 29611

Seneca
322 Union Station
Seneca, SC 29678

Simpsonville Clinic
273 Harrison Bridge Road
Simpsonville, SC 29680

Williamston Clinic
301 E Main St
Williamston, SC 29697

Clemson Eye

Medical History

Patient Name: _____

Birth Date: _____ Today's Date: _____

Past Medical History

☐ None Apply	☐ Atrial fibrillation	☐ Hepatitis C	☐ Seizures
☐ Allergies	☐ Benign Prostatic Hypertrophy	☐ High blood pressure	☐ Sleep apnea
☐ Anemia	☐ Coronary artery disease	☐ High cholesterol	☐ Stroke
☐ Anxiety	☐ Dry Eye	☐ Irritable bowel syndrome	☐ Thyroid disease
☐ Arthritis	☐ GERD	☐ Kidney disease	
☐ Asthma	☐ Heart attack	☐ Migraines	☐ Flu Shot Date Rcvd: _____

☐ Diabetes ☐ Oral ☐ Insulin ☐ Diet-controlled A1C _____ Yr. of Diagnosis: _____

Past Surgical History

			Glaucoma laser in:
☐ None Apply	☐ Cataract Surgery	☐ Pacemaker	☐Right ☐Left ☐Both
☐ Angioplasty	☐ Cornea Transplant	☐ Shunt Tube	Laser of retinal tear in:
☐ Angio w/stents	☐ Heart Bypass	☐ Thyroid Surgery	☐Right ☐Left ☐Both
☐ Back Surgery	☐ LASIK		Retina surgery in:
			☐Right ☐Left ☐Both

Family History: Please indicate if you mother, father, or sibling(s) have or had any of the following:

☐ Family History Unknown

☐ No Relevant Family History

	Mother	Father	Sister(s)	Brother(s)
Cataract	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
"Lazy Eye"	☐	☐	☐	☐
Macular degeneration	☐	☐	☐	☐

Allergies

☐ No Known Allergies	☐ Moxifloxacin	☐ Prolensa	☐ Sulfa
☐ Amoxicillin	☐ Non-steroidal (Aleve, ibuprofen)	☐ Tetracycline	☐ Vancomycin
☐ Latex	☐ Penicillin	☐ Tobramycin	☐ Other: _____

_____ Patient Signature

_____ Tech Signature

Clemson Eye

Medical Records Release Form

Authorization for Use

Patient Name: _____ Date: _____

SSN: _____ DOB: _____

Release records from: _____

Email: _____

I authorize the custodian of records of: _____ or other person/entity (specifically describe) to disclose/release all medical records to: _____

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Please send the records to: Clemson Eye Clinic (circled) at the **fax** number below:

Anderson(Gville St) (864) 622-5020	Anderson (Fant St) (864) 225-1139	Clemson (864) 654-3275	Clinton/Laurens (864) 833-0520	Easley (864) 855-6850
Greenville (Halton) (864) 987-0036	Greenville (Pelham) (864) 292-2020	Greenville (Lasik) (864) 297-8777	Newberry (803) 276-4536	Powdersville (864) 295-3242
Simpsonville (864) 967-8582	Williamston (864) 847-6060			

Disclosure of Protected Health Information

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Name: _____ Signature: _____ Date: _____

Patient / Guardian / Guarantor

Name: _____ Signature: _____ Date: _____

Witness

Clemson Eye

Dry Eye Questionnaire

Patient Name or ID: _____ Date: _____

Have you ever been diagnosed with Dry Eye Disease or Ocular Surface Disease?

☐ Yes ☐ No When? _____

1. Have you used artificial tears in the last two hours? ☐ Yes ☐ No

2. Do you have any of the following symptoms?

- ☐ Redness
- ☐ Burning
- ☐ Light sensitivity
- ☐ Tired eyes, eye fatigue
- ☐ Foreign body sensation
- ☐ Fluctuating vision
- ☐ Scratchy feeling of sand or grit in the eye
- ☐ Itching
- ☐ Excess tearing / watering eyes
- ☐ Stringy mucus in or around the eyes
- ☐ Contact lens discomfort

Report the FREQUENCY of symptoms you are experiencing by using the numbering system below:

1 = Sometimes 2 = Often 3 = Constant

SYMPTOMS	1	2	3
Dryness, Grittiness or Scratchiness			
Soreness or Irritation			
Burning or Watering			
Eye Fatigue			

3. Are you being treated for any of the following conditions?

- ☐ Diabetes
- ☐ Arthritis
- ☐ Lupus
- ☐ Dry Eye
- ☐ Thyroid Condition
- ☐ Sjögren's Syndrome
- ☐ Rosacea
- ☐ Blepharitis

**** For Office Use Only*****

Doctor Signature: _____ Date: _____

Technician: _____

Tear Osmolarity: OD: _____ OS: _____

Clemson Eye

Lifestyle Questionnaire

Your Information

Name: _____ DOB: _____

Pharmacy Name: _____ Pharmacy Address: _____

Visual Functioning

Do you have difficulty, even with glasses, with the following activities?

Reading small print, pill bottle labels, newspapers, books or the telephone book? Yes ☐ No ☐
Seeing steps, stairs or curbs? Yes ☐ No ☐
Reading traffic signs, street signs or store signs? Yes ☐ No ☐
Doing fine handwork like sewing, knitting or carpentry? Yes ☐ No ☐
Writing checks or filling out forms? Yes ☐ No ☐
Playing games such as bingo, dominos or card games? Yes ☐ No ☐
Shaving or putting on your make up? Yes ☐ No ☐
Cooking? Yes ☐ No ☐

Symptoms

Have you been bothered by:

Poor night vision, color vision or double vision? Yes ☐ No ☐
Hazy and/or blurry vision? Yes ☐ No ☐
Seeing well in poor or dim light? Yes ☐ No ☐
Do you currently drive a car? Yes ☐ No ☐
Seeing rings or halos around light at night while driving? Yes ☐ No ☐
Glare caused by headlights or bright sunlight? Yes ☐ No ☐
Do you do a lot of night driving? Yes ☐ No ☐

On a scale of 1-5 (where 1 is none and 5 is a great deal), how much difficulty do you have driving:

1	2	3	4	5	
☐	☐	☐	☐	☐	during the day because of your vision?
☐	☐	☐	☐	☐	during the night because of your vision?

Lifestyle Considerations?

Occupation: _____ Currently Working ☐ Retired ☐

List your favorite hobbies, sporting / recreational / outdoor activities: _____

Do you use a computer frequently? Yes ☐ No ☐ Somewhat ☐
Do you do a lot of close detail work? Yes ☐ No ☐ Somewhat ☐
Have you ever tried monovision contact lenses? Yes ☐ No ☐ Somewhat ☐
If "yes", did/do you like it? Yes ☐ No ☐
Do you wear progressive/no-line bifocals now? Yes ☐ No ☐
Over your lifetime, have you generally been satisfied with your vision with prescription glasses? Yes ☐ No ☐

If "no", please explain: _____

Would you like to have, without glasses, good distance and near vision in good light, even if you might see some rings around lights at night? Yes ☐ No ☐ Maybe ☐
Have you had LASIK? Yes ☐ No ☐

Do you have any specific vision concerns? _____

Cataract Surgery is optional.
Based on your vision, do you want to have cataract surgery? Yes ☐ No ☐

Name (print): _____ Date: _____
Patient / Guardian / Guarantor

Signature: _____