



SAME DAY SURGERY RESERVATION FORM

Fax (561) 338-7785

MD/OD Name: _____

Office Location: _____ Phone: _____

Patient Name: _____

Patient's Telephone # (Home) _____ (Cell) _____

Diagnosis: Cataract Glaucoma Operative Eye: OD OS Date of Surgery: _____
 Refractive IOL Standard IOL

Patient's Insurance Information: PLEASE FAX COPIES OF INSURANCE CARDS

Medicare/Primary Insurance: _____

Secondary Insurance: _____

Social Security #: _____

Does the patient's insurance policy cover prescriptions? YES NO

Brief Medical History:

Do you require oxygen YES NO

Are you on chemotherapy YES NO

Have you had surgery, within the last 3 months? YES NO

Ocular Hx:

List Eye Meds: _____

The majority of Commercial Insurance carriers do not recognize co-management of eye care. Therefore, your patient will be returned to you after the 90 day post-op period is satisfied.

Previous surgery or laser treatment: OD _____

OS _____

Current Refraction: OD _____ 20/

OS _____ 20/

Present Spec Rx: OD _____ 20/

OS _____ 20/

Oldest Known Rx: OD _____ OS _____ Date: _____

Does patient require transportation? YES NO

Additional Comments: _____