IQ LASER VISION
THE VISION ELITE
*"Transforming lives by delivering clear vision"*

## PATIENT INFORMATION

Please fill out the blue sections.

Language Preference | Date

Name

Social Security

Address

Street

City | State | Zipcode

Birthdate | Age

Sex ○ M ○ F ○ Single ○ Married

Cell Phone

E-mail

Occupation

Employer

Address

Street

City | State | Zipcode

## HOW DID YOU HEAR ABOUT IQ LASER VISION

Please circle and provide a name on how you first heard about us.

| | | | |
|---|---|---|---|
| Friend/Family name | | Instagram | |
| Facebook | | Radio | |
| Insurance | | Internet | |
| Brochure / Card | | Event(s) | |
| Other | | Eye Doctor | |

## YOUR CURRENT EYE DOCTOR

Please indicate your current eye doctor. We may request to ask for your previous records and prescription to better treat your case.

Company Name

Doctor Name

Location

**To better assist you today, please answer the following.**

### REASONS FOR WANTING LASER VISION CORRECTION

- ○ Hate wearing contacts / glasses
- ○ Recreational activities / Sports
- ○ Need improved vision for work
- ○ Other : _____

**What has prevented you from having Laser Vision Correction in the past ?**

**How soon do you want your Laser Vision Correction procedure?**

- ○ Today
- ○ This month
- ○ This year
- ○ Other : _____

**Have you had another Laser Vision Correction Consultation before ?**

- ○ Yes
- ○ No

IQ LASER VISION
THE VISION ELITE
*"Transforming lives by delivering clear vision"*

# Consent for the Use of Dilating Eye Drops

Dilating eye drops are used to enlarge the pupils, allowing our physicians to examine the inside of your eye. For many types of eye examinations, this is usually a requirement.

Dilating eye drops will usually cause blurred vision. The length of time that your vision will be blurred, and the degree to which you eyesight is impaired as a result, varies from person to person. It is not possible for your ophthalmologist to predict how much or how long your vision will be affected.

Driving, even in low-light conditions, may be difficult or impossible after an examination with dilating drops, and, if possible, you should not drive yourself afterwards. Instead, we strongly suggest you make alternative arrangements for transportation after your examination. If you do choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself or others. Also, we strongly suggest you use sunglasses to reduce your increased sensitivity to light while driving.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the use of dilating drops. This is extremely rare and treatable with immediate medical attention. If you experience any sharp pain in the eye, please notify us or seek medical attention immediately.

I _____ (Patient Name) hereby authorize

Dr. Robert T. Lin, Dr. Erica T. Liu, Dr. Gregory Phan, Dr. Paul Kouyoumjian, Dr. James Kao and/or his or her ophthalmic assistants or technicians to administer dilating eye drops during the course of my treatment. I understand that these eye drops are necessary to diagnose my condition. I further understand and acknowledge that I have been warned of the potential risks that dilating eye drops may have on my ability to drive and will take appropriate steps to reduce this risk by not driving immediately after my eyes have been dilated or by wearing sunglasses while driving.

Patient (or patient's authorized representative):

_____ Date: _____

Witness:

_____ Date: _____

Rev 13.09.21