BERG·FEINFIELD
VISION CORRECTION

Consultation Office Location: ***(please check one)***

❒13320 Riverside Dr., Suite 114
Sherman Oaks, CA 91423
Phone: 818-501-3937
Fax: 818-980-0651

❒2625 W. Alameda Ave., Suite 208
Burbank, CA 91505
Phone: 818-980-2020
Fax: 818-845-1916

❒1936 Huntington Dr., Suite A
South Pasadena, CA 91030
Phone: 626-795-9793
Fax: 818-845-1916

❒9100 Wilshire Blvd., Suite 852W
Beverly Hills, CA 90212
Phone: 866-273-3327
Fax: 818-845-1916

LASIK Consultation Request Form

Today's Date Last name:_____First name:_____

____/____/___ aka _____ Male / Female Date of Birth: _____/_____/_____

Home/Daytime Phone (_____)_____Mobile Phone (_____)_____Best # to call: ❒Home/Daytime ❒Mobile

Email Address: _____

Street Address: _____City: _____State: ____ Zip:_____

Procedure Discussed: **OU / OD / OS / MONOVISION**

❒Conventional/Custom ❒LASIK ❒IntraLASIK (All laser) ❒PRK ❒RLE/CLE ❒ICL ❒Intacs/Crosslnking (Exam fee applies)

Quoted Price $**_____with One Year Enhancement Included **$_____with Lifetime Commitment

Referring Doctor: _____**Office Location**_____ ***(city only)***

O.D. Phone: (_____)_____ Fax: (_____)_____

Ocular History:_____

Medical History:_____

Has patient had previous eye surgery? ❒Yes ❒No If Yes, there will be an applicable exam fee, or we will accept insurance for the visit.

Current Medications:_____

Allergies:_____

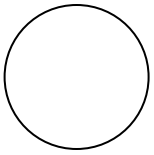
Contact Lens History: # of year(s) worn _____ **Daily Soft / Soft Toric / Gas Permeable (RGP)** *(Please circle one)*

OD:_____20/____ Contact Lens Power OS:_____20/____

Examination

OD		OS
_____	**Uncorrected Visual Acuity**	_____
_____20/____	**Current Spectacles**	_____20/____
_____20/___ Add:____	**Manifest Refraction**	_____20/___ Add:____
_____20/____	**1% Mydriacyl Refraction**	_____20/____
	(or 1% Tropicamide)	
_____	**Keratometry**	_____
_____	**Pachymetry** *(if available)*	_____

Dominant Eye: _____



_____ **Lids / Lashes / Lacrimal** _____

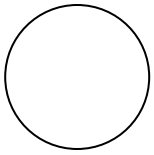
_____ **Conjunctiva** _____

_____ **Cornea** _____

_____ **Anterior Chamber** _____

_____ **Iris** _____

_____ **Lens** _____



C/D_____ Macula_____ Dilated Fundus Exam C/D_____ Macula_____

_____ **Periphery** _____

Doctor's Signature:_____ Exam Date:_____

PLEASE FAX FORM TO OUR REFRACTIVE SURGERY DEPARTMENT AT (818) 845-1916.

FOR OFFICE USE ONLY: LASIK Consult Scheduled _____/_____/_____ @ Sherman Oaks / Burbank / So. Pasadena / Beverly Hills

Initial Call _____/_____/_____ Faxed to OD _____/_____/_____ _____ (initials)

❒Left message ❒Spoke to patient, will check schedule and call back ❒Not interested at this time, follow-up in ____ weeks / months

_____