LASIKPRO
EXPERIENCE OUR DIFFERENCE

PATIENT REGISTRATION

Name _____
Last First M.I. Preferred Name

Date of Birth: _____Age: _____Gender: _____

Address: _____
City State Zip

Home Phone: _____Work Phone: _____Cell: _____

E-mail address: _____ Preferred Contact: _____

Employer: _____ Occupation: _____

EYE CARE PROVIDER INFORMATION:

Name of Eye Doctor: _____ Date of Last Exam: _____

Did your eye doctor refer you to us? _____ Did your eye doctor recommend refractive surgery? _____

Vision Insurance Provider _____ Have you contacted this provider regarding LASIK coverage? _____

TO BETTER UNDERSTAND YOUR VISION NEEDS, PLEASE ANSWER THE FOLLOWING OR STATE N/A:

Hobbies/Sports/etc.: _____

How long have you been considering refractive surgery? _____

When would you be interested in having refractive surgery? _____

Anything else you'd like us to know: _____

ADDITIONAL INFORMATION

How did you hear about us? _____

Please share with us your favorite radio station(s): _____ TV station(s:) _____

Newspaper(s): _____

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Name (Last): _____ (First): _____ (M.I.): _____

MEDICAL INFORMATION

Medication Allergies: _____ None List: _____
_____
_____

Current Medications: _____ None List: _____
_____
_____

Circle all that apply:	Arthritis	Lupus	Healing Problems/Keloid Scars
	Diabetes	Asthma	HIV or other autoimmune disorders
	High Blood Pressure	Depression	Pregnant/Breastfeeding – or – planning to Become pregnant within next 6 months.
	Tuberculosis	Smoker	Health Care Worker/Patient Care Contact
	Pacemaker	MRSA/MRSA Carrier	Other: _____

EYE HISTORY

Circle all that apply:	Cataracts	Glaucoma, you or family	Keratoconus, you or family
	Double Vision	Corneal Abrasion	Amblyopia (lazy eye)
	Strabismus (crossed eyes)	Retinal Tear/Detachment	Trauma/Foreign body/Scar
_____ No past eye history	Dry Eyes	Herpes Simplex/Zoster	Recurrent Corneal Erosion

PAST EYE SURGERY

	PRK	Muscle Surgery	Cataract Surgery
	RK/AK	Retinal Surgery	Glaucoma Surgery
_____ No past eye surgery	ALK/LASIK	Corneal Transplant	Other: _____

CONTACT LENS HISTORY

	No Contact Lenses	Soft Toric	
	Soft Daily Wear	RGP – Years Worn:	_____
	Soft Overnight Wear	PMMA – Years Worn:	_____
Date contacts were last worn:	_____	Difficulty with Contact Lens wear?	_____
		If yes, please explain:	_____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Relationship: _____
Phone Number: _____

By signing below, you:

1. **Acknowledge that you have been informed of the privacy practices and patient bill of rights**
2. **Acknowledge that you have access to a copy of these documents in the center.**
3. **Agree that all information given on this form is true to the best of your knowledge.**

_____ _____
Signature of patient or personal representative **Date**

_____
If personal representative, please print your name and describe your relationship to the patient