

Patient Information Form

Patient Name _____			Age _____	Birth Date _____
Address _____			Home Phone _____	
_____			Work Phone _____	
(City) _____	(State) _____	(Zip) _____	Cell Phone _____	
Occupation _____			Employer _____	
Insurance _____			Cardholder SSN _____	

Major Reason for Visit: _____
Type of Visit: Routine Emergency Laser Vision Consultation Medical 2nd opinion

Will you be using insurance to help pay for your visit? Yes No If yes, please specify type _____
Approximate Date of Last Exam _____ **Location** _____

Do you wear eyeglasses: Yes No **They are for:** Distance Reading Full time
Do you wear contact lenses: Yes No **Type:** Soft Gas Permeable
Have you ever worn contacts in the past: Yes No

Any history of an eye injury or surgery: Yes No explain _____

Any family history of eye disease: Yes No
If yes, circle all that apply: Glaucoma Macular Degeneration Cataracts Diabetic Retinopathy Retina Detachment

Are you experiencing any of the following? Check all that apply
__ blurry vision __ redness __ itching __ watery eyes __ dry eyes __ flashing lights __ floating spots
__ eye pain __ double vision __ headaches __ eyestrain __ swelling __ discharge

Have you been diagnosed with any of the following?
__ High blood pressure __ Anxiety __ Allergies
__ High cholesterol __ Depression __ Arthritis
__ Diabetes __ Migraine __ Infectious disease (HIV, Hepatitis, etc)
__ Thyroid __ Seizures __ Autoimmune disease (Lupus, TB,
__ Cancer specify type: _____ __ Other conditions: _____

Are you currently taking any medications? If yes, please list _____

Primary Care Physician: _____ **Phone** _____

Are you interested in learning more about Laser Vision Correction? Yes No
Would you like us to send a friendly reminder for your next eye exam? Yes No

Payment is expected at the time services are rendered. Complete balance is due before any prescriptions or materials are given. Patient is responsible for any amount not covered by insurance.

SIGNED _____ DATE _____