

Tell Us About Yourself The Laser Institute Patient Registration

Name (Last):			(First):		(M.I.)	Preferre	ed Name:			
Date of Birth:	Month:	Day:		Year:	Age:	Gender	:			
Address:										
City:			_ State/Province	ce:	Zip/Posta	l Code:		Country:		
Home Phone: _			_ Work Phone:		Ce	ell:				
Email:				Preferred Cont	tact: Ho	ome #	Cell#	Work #	E-Mail	
Employer:			Occi	ıpation:			S	.S.#:		
Emergency Con	tact:			Pho	ne:		Relations	hip:		
HOW DID YO	U HEAR ABO	UT THE LASI	ER INSTITUT	E?						
Please specify:										
EYE DOCTOR										
Who is your Ey	e Doctor?					Date of	Last Exam:			
Did your Eye D	octor refer you	to The Laser In	stitute?	Yes No						
Medical / Vision	n Insurance Pro	vider:								
					ider regarding a			No		
TO BETTER U	JNDERSTANI	YOUR VISIO	ON NEEDS, PL	EASE ANSW	ER THE FOLI	OWING:				
Hobbies / Sport	s / etc									
When would yo										
Anything else w	ve should know	?								
			PL	EASE PROCI	EED TO PAGE	2				
THE INFORM	IATION BELO	OW IS FOR IN	TERNAL USE	ONLY.						
Candidate	Non-Cand	idate <i>Reason</i>	: ICL	Presbyopia	Thin Cornea	s Kerat	oconus O	ther		
Procedure:	LASIK	Surface Abla	tion AK		Other:		(Co	onventional	Custo	m)
Technology:	VISX	Autonomous	Intr	aLase	Other:		Lifetime Con	mmitment:	Yes	No

Tell Us About Yourself The Laser Institute Patient Registration (Page 2)

Name (Last):		(First):		(M.I.)	
MEDICAL INFORM Medication Allergies:	MATION: None				
Medication:	None				
General Health Problems:	None	·			
(Check All that Apply)		Arthritis Diabetes High Blood Pressure Tuberculosis (TB)	Lupus Asthma Pregnant / Breast Feeding	Healing Problems / Keloid HIV Pacemaker	
EYE HISTORY:					
Past Ocular History: (Check A	All that Apply)	Cataracts Keratoconus Amblyopia / Lazy Eye	Double Vision Corneal Abrasion Retinal Tear / Detachment	Glaucoma Strabismus Trauma / Foreign Body / Scar	
No Past Eye History		Dry Eye	Herpes Simplex / Zoster	Recurrent Corneal Erosion	
Past Ocular Surgery: (State W	hich Eye)	PRK RK / AK	Muscle Retinal Surgery	Cataract Glaucoma Surgery Other Eveloir	
No Past Eye Surgery		ALK /LASIK	Corneal Transplant	Other – Explain:	
Contact Lens History		No Contact Lenses Soft Daily Wear Soft Overnight Wear	Soft Toric RGP – Years Worn: PMMA – Years Worn:		
Date Contacts Were Last Wo	rn:		Difficulty with Contact Lens Wear?	Yes No	
If Yes, please explain:					
	ion, your eye do	ctor will dilate your eyes with a	pupil dilator drop. It is recommended that	you have a driver if	
Acknowledge that	you have access	formed of the Privacy Practices to a copy of these documents in is ture to the best of your knowl	the center.		