LASER EYE INSTITUTE

CONSULTATION PATIENT INFORMATION

Last Name: _____
First Name: _____
Address: _____
City: _____
State: _____ Zip: _____
E-Mail Address: _____
Social Security #: _____-_____-_____

Date of Birth: _____/_____/_____
Gender: ( ) Male ( ) Female Age: _____

Marital Status: ( )Single ( )Married ( )Divorced ( )Widowed

Occupation: _____
Employer: _____
Home Phone: (_____) _____-_____
Cell Phone: (_____) _____-_____
Work Phone: (_____) _____-_____
How did you hear about us? _____
If a patient referred you, specify whom:
_____
Primary Care Dr: _____

Emergency Contact:_____
Relationship:_____
Contact Phone:(_____) _____-_____

INSURANCE INFORMATION

Medical Insurance Plan Name: _____ **Vision Insurance Plan Name:_____**

MEDICAL HISTORY

Approximately when was your last eye exam? _____ By whom? _____
Any family history of Glaucoma or other diseases: _____
Have you ever had eye surgery? ( ) Yes ( ) No If so, what type and when: _____
Have you ever had an eye injury? ( ) Yes ( ) No If so, what type and when: _____
Please list all medications you are currently taking: _____
_____
Do you have any medical allergies? ( ) Yes ( ) No If so, what type: _____

Please check any of the medical problems that you currently have or have had in the past:

High Blood Pressure	( ) Yes ( ) No	Lung Disease	( ) Yes ( ) No	Cancer	( ) Yes ( ) No
Heart Disease	( ) Yes ( ) No	Tuberculosis	( ) Yes ( ) No	Diabetes	( ) Yes ( ) No
Rheumatoid Arthritis	( ) Yes ( ) No	Liver Disease	( ) Yes ( ) No	Thyroid Disease	( ) Yes ( ) No
Keloid Former	( ) Yes ( ) No	Hepatitis	( ) Yes ( ) No		

Do you smoke? ( ) Yes ( ) No Did you ever smoke? ( ) Yes ( ) No How Many Years? _____
Do you drink alcohol? ( ) Yes ( ) No ( ) Socially ( ) Moderately
Are you pregnant? ( ) Yes ( ) No

Release of Information:
I hereby authorize the attending physician to release my information acquired in the course of examination or treatment and allow a photocopy of my signature to be used.
Claim Payment Authorization:
The subscriber hereby authorizes his/her insurance company(s), at its option to issue indemnity checks to the provider rendering services.
Patient Responsibility: I understand that I am being seen for a complimentary LASIK consultation to determine my ability to have LASIK or other types of vision correction procedures. I further understand that the Laser Eye Institute may not be able to write a prescription for either contact lenses or glasses as the necessary tests may not be done during a LASIK consultation. However, if I received a prescription a fee may be incurred.
The initial refractive consultation is complimentary, except in cases where previous vision correction procedures have been performed. Any medical information or records obtained from the consultation are used solely for the purpose of determining whether the patient the patient is a candidate for the procedure. This is not a routine eye examination, if however you ask the doctor to examine a condition not related to the screening for LASIK the doctor will inform you that you may either need to schedule a comprehensive ophthalmological eye examination, or convert the LASIK consultation into a comprehensive eye examination.

Signature of Patient: _____ Date: _____/_____/_____