FRESH LOOK LASER EYE CENTERS
PATIENT REGISTRATION FORM

NAME: _____DATE:_____

ADDRESS: _____DATE OF BIRTH:_____

CITY: _____ STATE:_____ ZIP:_____

HOME NUMBER: _____ WORK:_____ CELL: _____

EMAIL ADDRESS:_____ SOC SEC #:_____

SEX: M F MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

EMPLOYER NAME: _____ ADDRESS: _____

EMPLOYER PHONE: _____ OCCUPATION: _____

REFERRED BY: _____

**MEDICAL HISTORY** (please check any of the following conditions you have experienced)

___Asthma ___Arthritis ___Diabetes ___High Blood Pressure ___Fainting/Seizures
___HIV ___Pacemaker ___ Healing Problems ___Other(please list below)
___Autoimmune disorder _____

Medications currently taking (please list):_____

_____

Medication allergies:_____

## OCULAR INFORMATION

**Past Ocular History**: please check all that apply
___None ___Glaucoma ___Retinal Tear/Detachment ___Trauma to eye
___Cataracts ___Dry Eyes ___Herpes Simplex/Zoster ___Amblyopia/Lazy Eye
___Keratoconus ___Strabismus ___Recurrent corneal erosion

**Previous Ocular Surgical History:**
___PRK ___RK/AK ___Cataract
___Corneal ___Muscle ___Retinal Surgery

**Contact Lens History: Number of years worn _____Date contacts last worn:_____**
___Daily Soft ___Soft Toric ___Soft Overnight
___Rigid Gas Perm

I authorize examination of myself or the patient for whom I exercise power of attorney.

Signature:_____Date:_____