

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: _____