

Vermont Laser Vision at Timber Lane

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LASIK PATIENT REGISTRATION FORM

Name: _____ Date: _____

Address: _____

City/State: _____ County: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Phone #: Home Work Cell Alternate Phone #: Home Work Cell

Email Address: _____

Date of Birth: _____ SS#: _____ Male Female

Marital Status: Single Married Separated Divorced

Occupation: _____ Full Time Part Time

Employer: _____

Hobbies: _____

How did you hear about us?

Radio: _____ Newspaper: _____

Friend/Relative – Name: _____

Referring Physician – Name: _____

Referring Eye Doctor – Name: _____

Television: _____

Other: _____

Current ophthalmologist/optometrist: _____

Primary Care Physician: _____ Address: _____

Medical Insurance: _____ Policy # _____

How long have you worn glasses? _____

Has your prescription been changing regularly? Yes No

Are You A Contact Lens Wearer? No Yes

Soft Hard Gas Permeable Extended Wear

Total years worn: _____ Last worn when? _____

Have you ever worn lenses for monovision to help reading? Yes No

In Case of Emergency Notify: Name: _____

Phone: _____

