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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 ☐ Other

Occupation: _____ ☐ Full Time ☐ Part Time
Employer: _____
Hobbies: _____

How did you hear about us?
☐ Radio: _____
☐ Newspaper/Print: _____
☐ Television: _____
☐ Event: _____
☐ Friend/Relative – Name: _____
☐ Referring Physician – Name: _____
☐ Referring Eye Doctor – Name: _____
☐ Other: _____

Current ophthalmologist/optometrist: _____
Primary Care Physician: _____ Address: _____
Medical Insurance: _____ Policy #: _____

How long have you worn glasses? _____ Has you prescription been changing regularly? ☐ Yes ☐ No
Are You A Contact Lens Wearer? ☐ No ☐ Yes
☐ Soft ☐ Toric ☐ Hard ☐ Gas Permeable ☐ Extended Wear
Total years worn: _____ Last worn when? _____
Have you ever worn lenses for monovision to help with reading? ☐ Yes ☐ No

What is the name and location of your preferred pharmacy? _____

If you proceed with laser vision correction are you willing to share your experience with potential future patients*?
☐ No ☐ Yes If Yes, what is the best way for you to be reached? ☐ Phone ☐ E-mail

*You will be contacted by Vermont Laser Vision before we provide potential patients with your contact information. At any time, you may ask to be removed from this list.

In Case of Emergency Notify: Name: _____
Phone: _____

Does Vermont Laser Vision have your permission to discuss your health care with your emergency contact? ☐ Yes ☐ No