Patient Registration

Name: ____ Date of Birth: __________________ Age: ____________
(First) (Middle) (Last)

Address: ______________________________________ City: ______________________ State: ________ Zip: __________

Email Address: ____ Cell Phone: ( ) ____________________

Home Phone: ( ) _______________________ Work Phone: ( ) ______________________________ Ext: __________

Patients Sex: __Male ___Female Marital Status: **S M W D** Social Security #: _______________________________

Employer: ____ Occupation: _______________________

Employer Address: ___________________________________ City: ____________ State: _______ Zip: ________________

Emergency Name & Phone #: ____ ( ) ___________________

How did you learn about Travers Lasik Vision Care?
___ Web Search ___ Radio ___ TV ___ Newspaper ___ Magazine ___ Previous Patient ___ Mailer
If referred by a previous patient, who was it? ____

Did you consult with friends or family members who have had laser vision correction prior to this visit? ☐ Yes ☐ No
Did you visit our website at www.Traverslasik.com prior to this visit? ☐ Yes ☐ No
Will you use funds from an employer sponsored flexible spending plan to help pay for this procedure? ☐ Yes ☐ No
Did you visit any other laser vision correction providers prior to choosing Travers Lasik Vision Center? ☐ Yes ☐ No
If Yes, how many others? ____________________________
How long have you been considering laser vision correction? ____
Is your current eyeglass or contact lens prescription about to expire? ☐ Yes ☐ No

Travers Lasik Vision Center features All Laser Lasik (bladeless) technology. How important was this in your decision to visit us for an eye exam?

☐ Very important
☐ Somewhat important
☐ Not important
☐ Did not know at time appointment was made

Do you or have you ever been treated for the following: (check only those that apply)

☐ Collagen, vascular, autoimmune, or immunodeficiency disease (e.g. Arthritis, Lupus, HIV)
☐ Show signs of keratoconus (a corneal disease) or have any other condition that causes thinning of your cornea
☐ Herpes eye infections
☐ Taking accutane (inostretinoin) for acne treatment or cordarone (amiodarone hydrochloride) for controlling normal heart rhythm.
☐ Diabetes
☐ Double vision

CONTINUED ON BACK

Eye History

Do you primarily: ☐ Wear glasses ☐ Wear contact lenses? ☐ Wear both contact lenses and glasses equally?
Who prescribed your glasses/contacts? ________________________________ How old are they?_________________
Do your glasses have prism in them? ☐ Yes ☐ No
What type of contact lenses do you wear? ☐ Soft ☐ Toric for astigmatism ☐ RGP
Number of years you have worn contacts ___________Average wear time per day and times a week_______________
Do you sleep in your contact lenses? ☐ Yes ☐ No
Are you currently wearing your lenses? ☐ Yes ☐ No
Do you have trouble with distance vision? ☐ Yes ☐ No
Do you have trouble with near vision? ☐ Yes ☐ No
Do you have trouble with night vision or bright lights? ☐ Yes ☐ No
Have you ever had any prior surgery/laser treatments to your eye (s)? If yes, please describe ______________________
____
Have you ever had an eye trauma (i.e. Scratched cornea, something lodged in an eye, etc.)? If yes, please describe: _____
____
Have you ever been diagnosed with an eye condition / disease? (i.e. glaucoma, strabismus, kerataconus, dry eye, lazy eye as a child, etc.)? If yes, please describe: ____
____
Are you currently using any eye medications? If yes, please list: ____
____
Is there any family history of kerataconus, corneal diseases or blindness. If yes, please describe and note the relation to the individual: ____
Do you or have you ever been treated for (check only those that apply)

☐ Diabetes type 1 ☐ Diabetes type 2 If so, how long? _________________Are you using Insulin?_______________

☐ Pace maker	☐ Heart disease	☐ Heart attack	☐ Bypass surgery
☐ Stroke	☐ High blood pressure	☐ Neurological Disorders	☐ Lung Problems
☐ Seizures	☐ Prostate disease	☐ Bleeding disorders	☐ Liver disease
☐ Hepatitis B or C	☐ Kidney stones/infections	☐ Auto-immune disease	☐ Rheumatic disorders
☐ Ulcers	☐ Stomach Problems	☐ Keloids	☐ Sinus problems

☐ Cancer or tumor, Type: ____ ☐ Other ______________________
List all surgeries you have had: ____

Are you currently pregnant or nursing? ____

Medications

List all medications that you are **ALLERGIC** to (i.e. latex, iodine, valium, antibiotics, steroids, etc.) If yes, please list :______
____
____
List all medications and **dosages** that you are **CURRENTLY** taking, including all over the counter meds: _______________
____
____

At what phone numbers may we leave messages that include medical information?
☐ All ☐ Home ☐ Cell ☐ Work ☐ None

Please sign and date below that you have received a copy of our HIPPA consent form and understand our privacy policy.

_______________________________________ ____________
Signature of Patient Date