



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

Not important

Somewhat 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