

Patient Registration

Name: _____ Date of Birth: _____ Age: _____
 (First) (Middle) (Last)

Address: _____ City: _____ State: _____ Zip: _____

Email Address _____ Cell Phone () _____

Home Phone: () _____ Work Phone: () _____ Ext: _____

At what phone numbers may we leave messages that include medical information?

All Home Cell Work None

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 ___ Valpak

-If referred by radio, what station? G105 96Rock 94.7QDR

-If referred by TV, what channel? Wral(CBS) or other

-If referred by a previous patient, who was it? _____

- 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? _____
- 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 Did not know at the time appointment was made

Do you or have you ever been treated for the following:

- Y N**
 Collagen, autoimmune, or immunodeficiency disease (e.g. Arthritis (Rheumatoid not Osteo) , Lupus, HIV)
 If yes, what disease? _____ When were you diagnosed? _____
 Who is your treating physician? _____ May we contact this doctor? _____
 Do you take an immunosuppressant medication for this condition? **Y N** If yes, what? _____
- Show signs of keratoconus (a corneal disease) or have any other condition that causes thinning of your cornea
- Herpes eye infections
- Taking cordarone (amiodarone hydrochloride) for controlling 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
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)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Diabetes type 1 | <input type="checkbox"/> Diabetes type 2 → If so, how long? _____ | Are you using Insulin? _____ | |
| <input type="checkbox"/> Pace maker | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heart attack | <input type="checkbox"/> by-pass surgery |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Prostate disease | <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Kidney stones or infection | <input type="checkbox"/> Rheumatic disorders | |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Sinus problems | |
| <input type="checkbox"/> Cancer or tumor, Type: _____ | | <input type="checkbox"/> 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: _____

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



RELEASE REQUEST OF MEDICAL INFORMATION
TRIVERS LASIK VISION CARE

DOB: _____

(Please print your name above - First, Middle, Last)

Dr. Travers may require a copy of your previous eye records to provide you the best possible care.

Please take a moment to fill out your **primary eye doctor's information below.**

I authorize: _____

(Please print above - Eye Doctor's Name and/or Practice Name)

(Please complete a separate sheet if more than one Doctor and/or Practice)

Street Address: _____

City, State, and Zip: _____

Phone: (_____) _____

Fax: (_____) _____

To release **all medical records** pertaining to my health / eye examinations
(also, if available, please include AR Strip and K's, going back 2 years)

Please submit to: Travers Lasik Vision Center
2501 Atrium Drive, Suite 200
Raleigh, NC 27607
Phone# (919) 510-6830
Fax # (919) 510-6835

Patient Signature

Date

Witness Signature