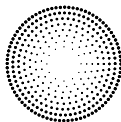


PATIENT INFORMATION

Patient's Name: ____ **Social Security** # We do not need it

Home Street Address: ____

City/State/Zip Code: ____

If Child, Parent's Name: ____

Cell: _______________________ **E-MAIL:**____________________________________

Sex: Male Female **Date of Birth:** ______/______/______ **Marital Status:** ___________

Occupation: __________________________ **Employer:** _____________________________

Referring Doctor: ___________________________ **Pharmacy Name & Phone:**_________________________________

IN CASE OF AN EMERGENCY, PERSON TO NOTIFY:

Name: _______________________________ ***Phone:*** ____________________ ***Relationship:*** _______________

INSURANCE INFORMATION

Insurance Company: ____

Please complete the following if the insured person is NOT the patient

Policy Holder Name: ____ ***Date of Birth:*** __________________

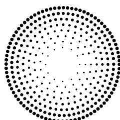
Relationship to the Patient: ***Parent*** ***Spouse***

Lifetime Authorization and Assignment of Benefits

I hereby authorize the physicians and staff of LaserVue to perform such treatments to me as may be prescribed by my attending physician during any and all my visits to LaserVue. I understand that I am financially responsible for all charges arising from services rendered to me by LaserVue. I hereby authorize LaserVue to file on any and all insurance for any charges that I incur. I request that all payments from any of these insurance's be mailed directly to LaserVue. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or any insurance company, any information needed to determine these benefits or the benefits payable for related services.

I acknowledge that I received a copy of LaserVue, LLC Notice of Privacy Practices

Patient's Signature: ________________________________ **Date:** ____________________



Medical History Information

Patient Name: ____

Who is your family physician? ____

Have you ever been treated/informed you have any of the below?

	Yes	No
Previous Eye Injuries	___	___
Glaucoma	___	___
Cataract	___	___
Retinal Detachment	___	___
Macular Degeneration	___	___
Diabetic Retinopathy	___	___
Amblyopia	___	___
Lazy/Cross Eye	___	___
Dry Eyes	___	___
Corneal Disease	___	___
Uveitis	___	___
Lasik	___	___
RK	___	___

	Yes	No
High Blood Pressure	___	___
Seasonal Allergies	___	___
Diabetes	___	___
Heart Problems	___	___
Asthma	___	___
Emphysema	___	___
Arthritis	___	___
Thyroid Disease	___	___
Hepatitis or Liver Disease	___	___
Kidney Problems	___	___
Tuberculosis	___	___
Bruise Easily	___	___
Autoimmune Disease (Lupus, Sjogren's, Rheumatoid)	___	___

List other medical conditions that apply to you ____

Has anyone in your immediate family ever been treated or informed they had any of the following?

	Yes	No	Relative
Glaucoma	___	___	________________________________
Cataract	___	___	________________________________
Retinal Detachment	___	___	________________________________
Macular Degeneration	___	___	________________________________
Amblyopia	___	___	________________________________
Lazy/cross eye	___	___	________________________________

Do you smoke? Yes ___ No___ Packs Per Day ____ Do you drink? Yes ___ No___ How much? ______________

Allergies: ____

Eye Medications:____

Medications:____

Are you pregnant? ___ Yes ___ No ___ N/A

Have you ever worn contact lenses? _____ Type: ____