Whitten Laser Eye Patient Registration

Name(last) _____________________________(first)__________________________ (M.I.)________ Preferred Name__________________

Date of Birth: __________________ Age: _______________ Gender: ______________ Married: ❑ Yes ❑ No

Address: ____

City:___________________________________ State:_____________________Zip________________

Home Phone:___________________________ Work Phone: ________________________________ Cell: ___________________________

Email: ____ Preferred Contact ❑ Home ❑ Cell ❑ Work ❑ Email

Employer:____ Occupation: ____

EYE CARE PROVIDER INFORMATION:

Who is your Eye Doctor? _____________________ Address: ___________________________________ Date of Last Exam: _______

Did your Eye Doctor refer you to our office? ❑ Yes ❑ No Did your Eye Doctor recommend an eye procedure? ❑ Yes ❑ No

Medical / Vision Insurance Provider: ____ Vision Coverage ❑ Yes ❑ No

Have you contacted your provider regarding your eye benefits? ❑ Yes ❑ No

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TO B ETTER UNDERSTAND YOUR VISION NEEDS, PLEASE ANSWER THE FOLLOWING OR STATE N/A:

Hobbies / Sports / Etc. ____

How often do you do these activities?____

How long have you been considering Refractive Surgery? ______________________________

What is your motivation for Refractive Surgery? ____

When would you be interested in having Refractive Surgery? ____

How did you hear about Whitten Laser Eye? ____

Have you served in the military or are you a military dependant? ______________ Branch: _____________________

PAST OCULAR SURGERY:

(state which eye) ❑ PRK ❑ RK/AK ❑ ALK ❑ LASIK ❑ Cataract Surgery

❑ Muscle Surgery ❑ Retinal Surgery ❑ Glaucoma Surgery

❑ No Past Eye Surgery ❑ Corneal Transplant ❑ Other ____

Contact Lens History: ❑ No Contact Lenses ❑ Soft Daily Wear ❑ Soft Toric (for Astigmatism)

❑ Soft Extended Wear ❑ RGP – Years Worn _____________

❑ PMMA – Years Worn _____________

Date Contacts Were Last Worn: _______________________

Difficulty with Contact Lens Wear? ❑ Yes ❑ No

If Yes, Please explain____

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MEDICAL INFORMATION:

Medical Allergies: ❏ None List:____

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Current Medications: ❏ None List: ____

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(Check all that apply):

❏ Arthritis ❏ Asthma ❏ Health Care Worker/ Patient Care Contact

❏ Diabetes ❏ Lupus ❏ Healing Problems

❏ High Blood Pressure ❏ Depression ❏ HIV or other Autoimmune Disorders

❏ Keloid Scars ❏ Tuberculosis (TB) ❏ Pregnant/Breastfeeding – or – planning to become pregnant within the next 6 months

❏ Pacemaker ❏ MRSA Carrier

❏ Smoker ❏ Other: ____

EYE HISTORY:

Past Ocular History (State Which Eye)

❏ Cataracts ❏ Glaucoma, you or family ❏ Keratoconus, you or family

❏ Double Vision ❏ Corneal Abrasion ❏ Amblyopia / Lazy Eye

❏ Strabismus ❏ Retinal Tear / Detachment ❏ Trauma / Foreign Body

❏ Scar ❏ Dry Eyes ❏ Recurrent Corneal Erosion

❏ No Past Eye History ❏ Herpes Simplex / Zoster

Emergency Contact Information:

Emergency Contact:______________________________ Relationship: _________________________

Phone Number: _____________________________ Cell Phone Number: _________________________

Prior to your procedure, your Eye Doctor or WLE will dilate your eyes with a pupil dilating drop. It is recommended that you have a driver if dilation drops are used. A consultation visit to WLE, to find out if you are a laser refractive candidate, does **NOT** constitute a full eye examination.

By signing below you:

1. Acknowledge that you have been informed of the Privacy Practices and your rights as a patient.
2. Acknowledge that you have access to a copy of these documents in the Facility.
3. Agree that all information given on this form is true to the best of your knowledge.

____ ____________________________

Signature of Patient or Personal Representative Date

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If Personal Representative, please print your name and describe your relationship to the patient