

## PATIENT REGISTRATION

4	GEORGE SIMO	N, MD		Date		
Patient Informa	tion:					
Name: First	Mi	Last	Birth Date: Month/Day	Age: y/Year	Sex: 🗆 M	D F
Address:	Street		City	State	Zip	
Home Phone: (	)		Cell Phone: (	)		
Work Phone: (	)		Email:			
Occupation:		Emplo	yer/Employer Address:			
Emergency Contac	ct:		Phone: ( )			
Social Network	ing:					
Have you visited o	our website at	www.lasikcustomvi	ision.com? 🛛 Yes 🗠 No	)		
Have you visited o	our Facebook	page? 🛛 Yes 🗆 No				
Do you use Faceb	ook?	🗆 Yes 🗆 No	How many Friends	?		
Do you use Twitte	r?	🗆 Yes 🗆 No	How many follower	rs do you have?		
Interest in LAS	IK:					
How did you hear	about us?	□ Radio □ TV	□ Internet Search □	Other - please spe	ecify:	
		□ Referral - what i	is their name?			
What activities/hol movies, reading, e		ou enjoy more with	out the dependency of	glasses/contacts?	? (e.g. swimmii	ng, skiing,
What is your bigge	est concern at	oout having LASIK?				
How long have you	u been consid	ering laser vision c	orrection?			
How many LASIK	providers are	you evaluating? 🛛	One 🗆 Two 🗆 More t	han two 🛛 Unsure	9	
Will you use funds	from an emp	loyer sponsored fle	xible spending plan to	pay for this proce	dure? 🗆 Yes	🗆 No
If our schedule all	ows, would yo	ou be interested in h	aving laser vision corre	ection today?	Yes 🗆 No 🗆	Maybe
Would you like Dr.	Simon to call	you prior to treatme	ent to answer any quest	tions? 🗆 Yes 🗆	No	

## **RELEASE OF INFORMATION**

I understand that this free consultation is for laser vision correction purposes only and is not a substitute for a routine eye exam. If I wish to have a copy of my exam records released to myself or another provider, I acknowledge that there may be a \$150 charge to me, if permitted under state law.

Signature	of	Patient
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Date

When was your last eye	exam?	Where or	r With Who?					
What type of vision prob	lem are you cu	rrently experi	encing?					
□ Decrease	d distance	Decreased ne	ear Diffici	ulty with i	night visio	n		
Do you think your vision	is stable?	′es □No □	Unsure If s	table, ho	ow long h	nas it been s	stable?	
How are you currently m □ Glasses:	anaging your y How old are y		on?					
	-			-		÷		
	□ Soft □ To					A	ontacts?	Yes 🗆 No
	How many ye	ars have you v	vorn them?	1	/vhen did	you last wea	ar them?	
Rate your satisfaction wi	th your curren	t glasses/con	tacts: 🛛					
217			Extremely S	Satisfied	Very	Somewhat	Not Very	Not at all
Have you experienced ar	y of these eye	issues within	n the last 6 m	onths?				
Dryness Dandy/Grit	ty Sensation	Burning/Stir	nging 🗆 Re	dness	D Tearing	g 🛛 🗆 Itchin	g 🗆 Allerg	gies
Trouble with night vision	Glare C	Halos 🛛 Li	ght sensitivity	D De	creased c	ontact lens	wearing time	3
Occasional Blurred Visio			•					14
		licion DEVIC	Abrasion or	Freelon			rt (aching)	
			e Abrasion or	Erosion		ar Discomfo	rt (aching)	
			e Abrasion or I	Erosion		ar Discomfol	rt (aching)	
Please list any eye drops	you are prese	ently using:					rt (aching)	
Please list any eye drops Have you or a family mer	you are prese nber (parent o	ntly using: r sibling) ever		osed wit	h or treat	ed for:	rt (aching) turn) - □ Si	elf 🛛 Fami
Please list any eye drops Have you or a family mer • Cataracts -  □ Self □ Fam	you are prese nber (parent o ily • Gl	ntly using: r sibling) ever	• been diagno □ Self □ Farr	osed wit	h or treat • Stra	<b>ed for:</b> bismus (eye		
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Please list any eye drops Have you or a family mer • Cataracts -  Self  Fam • Diabetes -  Self  Fam • Blindness -  Self  Fam	i <b>you are prese</b> <b>nber (parent o</b> ily • Gl ily • Re ily • Ke	ently using: r sibling) ever aucoma - etinal Disease - ratoconus -	■ <b>been diagno</b> ■ Self □ Fam ■ Self □ Fam ■ Self □ Fam	osed with hily hily hily	h or treat • Stral • Amb • Othe	<b>ed for:</b> bismus (eye blyopia (lazy er Corneal D	turn) - □ S eye) - □ Se isease - □ S	elf □ Famil elf □ Fami
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None

List all medications that you are ALLERGIC to:

None

List all previous surgical procedures that you have had:

None

Thank you for taking the time to fill out our registration. Feel free to ask us any questions.