California Center for
REFRACTIVE SURGERY

Date: ____/____/____

Registration Form

Contact Information

Last Name:		First & Middle Name
Address	City	State Zip
Date of Birth: / /	Age:	Sex: M F
Cell Phone	Home Phone:	Work Phone:

E-mail:

Occupation: Employer:

Emergency Contact:

Do you have medical Insurance? Yes No If Yes, please give us the name and the policy No. below

The Name of Insurance Company: Policy No.#

When was your last eye exam?

Any finding / Treatments??

How did you hear about us?

Medical History

List any medications you take (including oral contraceptives):

Are you allergic to any medications? Yes No
If yes, *list and Explain*:

Are you currently being treated for any medical condition? Yes No
If yes, *Explain*:

Are you pregnant or nursing? Yes No

Have you ever had or been told that you have:

General Eye Conditions	Yes	No	General Health Conditions	Yes	No
Glaucoma			Diabetes		
Cataracts			Thyroid		
Retinal Detachment/Disease			Heart Disease		
Lazy Eye/Amblyopia			Breathing Problems		
Eye Surgery			Auto-Immune Disease		
Dry Eye			Arthritis		
Eye Injury/Infection			High Blood Pressure		

Explain "Yes" Above or List other Condition(s):

Thank You for choosing CCRS!