Whitten Laser Eye Patient Registration

Name(last) _____(first)_____ (M.I.)_____ Preferred Name_____

Date of Birth: _____ Age: _____ Gender: _____

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? _____ Date of Last Exam: _____

Did your Eye Doctor refer you to our office? ❑ Yes ❑ No Did your Eye Doctor recommend and 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? _____

Is there anything else we should know? _____

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:_____

_____

_____

Current Medications: ❑ None List: _____

_____

_____

(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

❑ Pacemaker ❑ MRSA Carrier within the next 6 months

❑ Smoker ❑ Depression ❑ 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

_____

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