PATIENT REGISTRATION

Keil Lasik Vision Center

PATIENT INFORMATION

Name: **Birth Date:** **Age:** **Sex:** ___M___F

Legal First Nickname Legal Last mm/dd/yyyy

Address:

Street City State Zip

Cell: **Work:** **Email:**

Occupation: **Employer:**

Medical Insurance Provider:

Emergency Contact: **Relationship:** **Phone:**

Do you have a specialized Driver's License? ___None ___CDL ___Pilot ___Motorcycle ___Other:

INTEREST IN VISION CORRECTION

Rate your satisfaction of your current glasses/contacts:

___Extremely Satisfied ___Very ___Somewhat ___Not Very ___Not at all

What activities or would you enjoy more without the dependency of glasses/contacts? (Reading, swimming, movies, etc.)

How did you hear about us? (circle all that apply)

Co-worker Radio TV Friends/Family Physician Keil Lasik Patient Other: ______________________

Drive-by Walk-in Email Social Media Optometrist Google/Internet Search Our Website Seminar

How many surgeons are you evaluating for your procedure? ___One ___Two ___More than two

What is your biggest concern about having vision correction surgery?

How long have you been considering having vision correction surgery?

How soon would you like to have your vision correction surgery? ___ASAP ___1-4 wks ___1-3 mos ___>3mos

Will you use funds from an employer sponsored flexible spending plan to pay for this procedure? ___Yes ___No

How much would you estimate your glasses/contacts have cost in your lifetime?

How are you currently managing your vision needs:

I need correction for: ___Reading ___Distance ___Both

___Glasses How old are your current glasses? ____________ How many years have you been wearing glasses?_____________

___Contacts: Type ___Soft ___Toric ___Gas Perm Do you sleep in your contacts? ___Yes ___No

How many years have you worn contacts? ____________________ When did you last wear your contacts? ____________________

Please place and "X" on the following scale to describe your personality as best you can:

[-]

Easy going Perfectionist

Physician's Initial _____

MEDICAL HISTORY

Do you have or have you ever been treated for the following:

___Stroke	___Brain/nerve disorders	___Heart Disease	___Pregnant/Nursing in past 3 mo.
___Seizure	___Stomach Disorder	___Heart Attack	___Rheumatoid Arthritis
___Brain Tumors	___Digestive Disease	___Bypass Surgery	___Post Menopausal
___Ulcers	___Hepatitis B or C	___Other Heart Disease	___Inflammatory Bowel Disease
___Migraines	___Liver Disease	___High Blood Pressure	___Acne Rosacea
___Emphysema	___Kidney Stones	___Irregular Heart Rhythms	___Herpes Zoster (Shingles
___Asthma	___Kidney Infection	___Thyroid Disease	___Lupus
___Tuberculosis	___Nephritis	___Other Lung Disorders	___Cancer or tumor, Type:_____
___Prostate Disease	___Pneumonia	___Diabetes	___Other _____
___MS	___HIV/AIDS	___Sleep Disorders	___None of the above
___Sarcoid	___Psoriasis	___Keloids	

Do you have an implanted pacemaker, defibrillator, or other battery powered medical device? ___Yes ___No

Please list any previous surgical procedures that you have had: _____

Do you currently take any of the following medications? (Please check all that apply)

___Birth Control Pills	___Antihistamines	___Imitrex	___Hormone Replacement Therapy	___Antidepressants
___Diuretics (Lasix)	___Beta Blockers	___Cordarone	___Accutane (even previously)	___None of the above

List all current medications and dosage:_____

_____ ___I take no medications

List all medications that you are ALLERGIC to:_____ ___I have no known drug allergies

Primary Care Doctor's Name: _____ **Phone Number:**_____

EYE HEALTH HISTORY

Have you ever had any surgery, injury or laser treatments to the eye? ___No ___Yes:_____

When and where was your last eye exam? _____

Have you experienced any of these eye/health issues in the last 3-6 months?

___Stinging	___Tearing	___Decreased contact lens wearing time	___Light Sensitivity
___Dryness	___Glare	___Occasional Blurred Vision	___Trouble with night vision
___Redness	___Burning	___Double Vision	___Eye Abrasion or Erosion
___Itching	___Grittiness	___Ocular Discomfort (aching)	___None of the above

Have you or a family member (parent or sibling) ever been diagnosed with or treated for:

Cataracts ___Self___Family	Glaucoma ___Self ___Family	Keratoconus or other corneal disease ___Self___Family
Diabetes ___Self___Family	Retinal Disease ___Self___Family	Amblyopia (lazy eye) ___Self___Family
Blindness ___Self___Family	Strabismus (eye turn) ___Self ___Family	___None of the above

RELEASE OF INFORMATION/OTHER

I understand that this evaluation is for laser vision correction purposes only and is not a substitute for a routine eye examination. If I wish to have a copy of my examination records released to myself or another provider, I acknowledge that there may be a charge to me. I further understand that for internal training purposes only, my preoperative examination may be recorded with video and/or audio equipment. If stated that I was referred by my Managed Care plan, I attest that I am a current member or eligible dependent of the Managed Care plan that I have checked above. Should it be determined that I am not an eligible member or dependent, I agree to reimburse the amount of the plan discount. Any applicable Managed Care discount must be indicated before payment or it will be forfeited. I authorize Dr. Keil and Keil Lasik to access any medical information from other providers pertinent to my care.

_____ _____

Signature of patient Today's Date