

Schwartz Laser Eye Center

PATIENT INFORMATION

Please Print Clearly

FILL IN ALL BLANK AREAS

Date _____

Name Mr. Mrs. Ms. Miss _____
Last First Middle Initial

Date of Birth _____ Age _____ Male / Female Referred by: _____

Current Street Address _____ City _____ State/Prov _____ PC/Zip Code _____

Telephone/Home () _____ E-Mail _____

Telephone/Cell () _____ Work Telephone _____

Employer _____ Occupation _____

Name of Person to contact in case of emergency _____

Daytime telephone () _____ Relationship _____

INSURANCE INFORMATION (Required Information)

Insurance Provider _____ Provider Phone # () _____

Address Claims submitted to _____ City _____ State _____ Zip _____

SS # _____ Marital Status _____ Spouses Name _____

Spouses SS# _____ Spouses Birthdate _____ Primary Cardholder _____

OCULAR HISTORY

Eye medications presently taking _____

How old are your current glasses? _____ Years/Mos How often has your prescription changed? _____

Do you currently wear contact lenses? Y / N If yes, what type? _____ Soft Daily _____ Soft Toric _____ Soft Extended

How long have you worn contact lenses _____ Yrs/Mos _____ Hard/Gas Permeable _____ Monovision?

If Extended wear contacts, how often do you remove them? _____ Clean them? _____

When was your last eye examination? _____ Where? _____

Do you have any of the following or a history of the following? (Please answer all)

Iritis	Y / N	Retinal tear/detachment	Y / N	SPECIFY ANY OTHER EYE ISSUES: _____
Eye Injury	Y / N	Lazy eye/ Turned eye	Y / N	
Cataract	Y / N	Keratoconus	Y / N	
Glaucoma	Y / N	Family history of Glaucoma	Y / N	

Do you have a history of any eye surgeries? Y / N If yes, please specify _____

PLEASE SEE OTHER SIDE