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
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

SPECIFY ANY OTHER EYE ISSUES:______________________________
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Do you have a history of any eye surgeries? Y / N If yes, please specify ______________________________

PLEASE SEE OTHER SIDE