WOOLFSON EYE INSTITUTE

LASIK Patient Data Sheet

(This Information Is Confidential)

Patient Name: _____
First Middle Initial Last

Preferred Name (nickname, if different from first name): _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Employer: _____ Occupation: _____

Birth Date: _____ Age: _____ Sex: ❑ Male ❑ Female

Social Security No.: _____ Insurance Carrier: _____

Current Optometrist or Ophthalmologist: _____

How did you hear about us: ❑ Doctor ❑ Radio ❑ Magazine ❑ Billboard

❑ Other: _____ ❑ Relative/Friend – Name _____

Person to Notify in Case of Emergency: _____

Phone: _____ Relationship: _____

Authorization to Release Medical Information

I authorize Dr._____ (referring doctor) to disclose complete information to Woolfson Eye Institute concerning his/her medical findings and treatment of the undersigned.

Patient Signature: _____ Date: _____

Parent or Guardian signature, if patient is a minor: _____

Date: _____