Welcome to
ONE *to* ONE LASIK

Name_____Date_____

Address _____

City, State, Zip_____

Referred by _____Date of Birth_____

Social Security Number _____ M F Age_____

Home Phone ( ) _____Work ( ) _____

Fax Number ( ) _____Cell ( ) _____

E-Mail Address _____Pager ( ) _____

Emergency Contact_____Phone ( ) _____

Employer_____

Employer's Address_____

Occupation _____

Insurance Company (if applicable) _____

Policy Number _____

Motivation for Refractive Surgery _____

Medications_____

Allergies to Medications _____

Please Circle Yes or No for the following:

Contact Lens Wear	Y N	Diabetes	Y N
Eye Drops	Y N	Hypertension	Y N
Eye Surgery	Y N	Pregnant/Nursing	Y N
Glaucoma	Y N	Other _____	
Trauma	Y N	_____	
Cataract	Y N	_____	

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ONE *to* ONE LASIK™

The Laser Vision Specialists™