



LASERVISION | Wm Schlichtemeier, MD  
CORRECTION | Lance Kugler, MD

## Patient Information

Date \_\_\_\_\_

Legal Name:

\_\_\_\_\_  
Dr/Mr/Mrs/Ms/Miss      First      Middle      Last      Suffix

\_\_\_\_\_  
Nickname      Date of Birth      SS#

\_\_\_\_\_  
Street Address      City      State      Zip

\_\_\_\_\_  
Home Phone      Work Phone      Other/Cell Phone

\_\_\_\_\_  
Email Address      Sex: M or F (please circle)

\_\_\_\_\_  
Employer      Occupation/Job Title

\_\_\_\_\_  
Spouse      Spouse's Employer

\_\_\_\_\_  
Emergency Contact      Emergency Phone

\_\_\_\_\_  
Name of Primary Insurance      Name of Secondary Insurance

\_\_\_\_\_  
Insured's Name      Insured's DOB

\_\_\_\_\_  
Primary Care Physician

Were you referred by a medical doctor? Yes or No (please circle)

Were you referred by an eye doctor? Yes or No (please circle)

\_\_\_\_\_  
Who may we thank for referring you to our practice? Please provide their address if possible.

**Please complete this form and bring it with you. Please wear glasses at time of visit.  
Please present insurance card at check-in and current ID (drivers license).**

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**Health Insurance Portability and Accountability Act Waiver**

Because LASERVISION CORRECTION is bound by the rules of the Health Insurance Portability and Accountability Act (HIPAA), we are unable to provide any information to any person other than you without your consent. This includes information about your account, appointment times or prescriptions. Please list any persons or agencies that we have permission to release your information to.

(This information can be amended as needed.)

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**RELEASE OF INFORMATION**

I hereby authorize the release of medical records both written and oral, to insurance companies, employers, physicians, HCFA and any other institution or organization that may request information necessary to determine eligibility for health care benefits. I request that payment of authorized Medicare and insurance benefits be made to CORNEA ASSOCIATES PC. I hereby acknowledge that I received or have been offered a copy of the CORNEA ASSOCIATES PC Notice of Privacy Practices.

Signature \_\_\_\_\_ Date \_\_\_\_\_



## Health History

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Medication History

Please list all medications you are currently taking:

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Do you have a history of taking Flomax or similar medication for prostate issues?

Yes or No (please circle) \_\_\_\_\_

### Ocular History

Have you ever been diagnosed with any of the following eye problems? Yes or No, If so, please include which eye, using R for right eye, L for left eye, and B for both eyes.

Amblyopia/Lazy Eye     Dry Eye     Iritis  
 Cataracts     Fuch's Dystrophy     Keratoconus  
 Corneal Scar     Glaucoma     Macular Degeneration  
 Diabetic Retinopathy     Injury/Trauma     Retinal Detachment/Tear

Other \_\_\_\_\_

Have you had any eye surgeries? Yes or No (please circle)

Surgery	Eye	Date	Doctor	Doctor's City/State
Cataract				
CK				
Corneal Transplant				
Lasik				
Lid Surgery				
LTK				
PRK				
RK				
Retinal Detachment and/or Repair				
Strabismus/Muscle Surgery				
Yag Laser				
Other				

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### Personal History

Have you ever been treated for any of the following medical conditions?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Anesthesia Complications         | <input type="checkbox"/> Emphysema             | <input type="checkbox"/> Multiple Sclerosis  |
| <input type="checkbox"/> Anxiety                          | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Muscular Dystrophy  |
| <input type="checkbox"/> Asthma                           | <input type="checkbox"/> Fibromyalgia          | <input type="checkbox"/> Paraplegia          |
| <input type="checkbox"/> Back Problems                    | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Quadriplegia        |
| <input type="checkbox"/> Bipolar Disorder                 | <input type="checkbox"/> Hepatitis A or B or C | <input type="checkbox"/> Rosacea             |
| <input type="checkbox"/> Cancer                           | <input type="checkbox"/> Herpes Simplex        | <input type="checkbox"/> Seasonal Allergies  |
| <input type="checkbox"/> Cerebral Palsy                   | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Cervical Fracture                | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Depression                       | <input type="checkbox"/> Hypertension          | <input type="checkbox"/> Thyroid Dysfunction |
| <input type="checkbox"/> Diabetes (insulin dependent)     | <input type="checkbox"/> Lupus                 | <input type="checkbox"/> Other _____         |
| <input type="checkbox"/> Diabetes (non-insulin dependent) | <input type="checkbox"/> Migraines             |  |

Do you currently have any of the following?

- |  |   |                                    |
|--|---|------------------------------------|
| <input type="checkbox"/> Cochlear Implants | <input type="checkbox"/> Internal Defibrillator | <input type="checkbox"/> Pacemaker |
|--|---|------------------------------------|

Are you currently pregnant? Yes or No (please Circle)

Are you currently breastfeeding? Yes or No (please circle)

In the last 5 years, have you had any non-eye surgeries? Yes or No (please circle)

If so, please list and include date of surgery \_\_\_\_\_

### Patient Allergies

Please list all medications you are allergic to:

\_\_\_\_\_

Are you allergic to:

- |                               |                                |  |
|-------------------------------|--------------------------------|--|
| <input type="checkbox"/> Tape | <input type="checkbox"/> Latex | <input type="checkbox"/> Iodine/Betadine |
|-------------------------------|--------------------------------|--|

### Family Medical History

Do any of your grandparents, parents, or siblings have any of the following?

- |                                    |   |  |
|------------------------------------|---|--|
| <input type="checkbox"/> Adopted   | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Retinal Detachment or Disease |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Stroke                        |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Other _____                   |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Macular Degeneration |  |

### Social History

Do you drink? Yes or No (please circle) How Often? \_\_\_\_\_

Do you smoke? Yes or No (please circle) How Often? \_\_\_\_\_