PRECILASER

PATIENT REGISTRATION FORM

First Name:		**Last Name:**	
Address:			
City:	**Postal Code:**	**Country of Residence:**	
Date of Birth (YY/MM/DD):		**Age:**	**Gender:**
Health Card #:		**Expiry Date:**	
Home #:	**Business #:**	**Cell #:**	
Email address:			
Employer Name:			
Emergency Contact Person Name:			**Phone:**
Family Doctor:	**PH:**		**FAX:**
Eye Doctor:	**PH:**		**FAX:**

Has your doctor/optometrist sent a referral for you? ☐YES ☐NO

May we contact your eye doctor? ☐YES ☐NO

Approximate date of last eye examination:

Are you here for a surgical second opinion on a procedure done elsewhere? ☐YES

Why did you choose PreciLaser today?

How Did You Hear About Us?

☐Family / Friend	☐Optometrist
☐Instagram	☐Ophthalmologist
☐Facebook	☐Medical Doctor
☐Google	☐Flyer/Print Material
☐TikTok	☐Other:
☐Website	

I understand and agree to the following:

- **Laser vision correction & refractive consultations:** This comprehensive consultation is to determine candidacy for a custom vision correction procedure. It does not substitute for an annual eye exam. Laser vision correction & refractive procedures are not insured by RAMQ.
- Fees may apply for a copy of my records or transferring my information to another doctor.

In an effort to stay connected and provide important information about health and safety, services we offer, events, news items, product care and promotions, occasionally we would like to send you email updates. ☐ **I agree to receive these emails and understand that I can unsubscribe at any time.**

Date:_____

Patient Name:_____ **Patient Signature**: _____

PATIENT REGISTRATION FORM

Medical History		
Drug Allergies:	☐YES ☐NO List:	
Medications (List all):		
For what conditions are you taking medications?		
Any of these conditions:	☐ Rheumatoid arthritis ☐ Lupus/Scleroderma	☐ Diabetes: ☐ Controlled ☐ Uncontrolled
Drops/Ointments:	Type:	How Often:
Pregnant?	☐YES ☐NO ☐Trying	Breastfeeding? ☐YES ☐NO

Ocular History

Contact Lens Wear: ☐Soft ☐Soft Toric ☐Rigid Gas Permeable
Date contacts last worn:
Difficulty wearing for long periods of time? ☐YES ☐NO

☐Wear Reading Glasses

Personal Eye History

☐Light Sensitivity ☐Macular Degeneration

☐Keratoconus ☐Retinal Tear / Detachment

☐Strabismus or Amblyopia ☐Retinal Laser Treatment or Injections

☐Glaucoma ☐Eye Disease Specify:

☐Cataracts ☐Eye Surgery: How long ago? Specify:

Family Eye History

☐Keratoconus ☐Eye Surgery Specify:

Dry Eyes - Severity of Symptoms Scale (Without Contact Lenses)
0=No problems 1=Tolerable 2=Uncomfortable 3=Bothersome 4=Intolerable

	Rating		Rating
Dryness, Grittiness or Scratchiness		Difficulty Opening eyes in AM	
Tearing or Watery Eyes		Intermittent blurring	
Burning			

Payment Plans

Are you interested in learning more about payment plan options? ☐YES