

Tell Us About Yourself

TLC PATIENT REGISTRATION



Name (Last) _____ (First): _____ (M.I.): _____ Preferred Name: _____

Date of Birth: Month: _____ Day: _____ Year: _____ Age: _____ Gender: _____

Address: _____

City: _____ State/Province: FL Zip/Postal Code: _____ Country: U.S.A.

Home Phone: _____ Work Phone: _____ Cell: _____

Email: _____ Preferred Contact: Home Cell Work E-Mail

Employer: _____ Occupation: _____

EYE PROVIDER:

Who is your Eye Doctor? _____ Date of Last Exam: _____

Did your Eye Doctor recommend TLC? Yes No

TO BETTER UNDERSTAND YOUR VISION NEEDS, PLEASE ANSWER THE FOLLOWING OR STATE N/A :

Hobbies / Sports / etc. _____

How long have you been considering Refractive Surgery? _____

What is your motivation for Refractive Surgery? _____

When would you be interested in having Refractive Surgery? _____

I want to learn about payment plans that can make my procedure more affordable? Y or N

Anything else we should know? _____

HOW DID YOU HEAR ABOUT TLC?

Please specify Word of Mouth _____

THE INFORMATION BELOW IS FOR INTERNAL USE ONLY. PLEASE PROCEED TO PAGE 2

Candidate Non-Candidate Reason: Presbyopia Intacts Keratoconus Other: _____

Procedure: LASIK Intralase Conventional Custom AK/LRI RLE ICL PI

Surface Treatment: PRK / PTK / LASEK / EPI Other: _____

Technology: VISX Wavelight Other: _____ Lifetime Commitment: Yes No

Co-managing Doctor: _____

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Name (Last): _____ (First): _____ (M.I.): _____

MEDICAL INFORMATION :

Medication Allergies : None List: _____

Current Medications : None List: _____

- (Check All that Apply)
- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Lupus | <input type="checkbox"/> Healing Problems / Keloid Scars |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV or other Autoimmune Disorders |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Depression | <input type="checkbox"/> Pregnant/Breastfeeding - or - planning to become pregnant within next 6 months. |
| <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Smoker | <input type="checkbox"/> Health Care Worker / Patient Care Contact |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> MRSA Carrier | <input type="checkbox"/> Other : _____ |

EYE HISTORY :

- Past Ocular History: _____
(State Which Eye)
- | | | |
|--|--|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma, you or Family | <input type="checkbox"/> Keratoconus, you or family |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Corneal Abrasion | <input type="checkbox"/> Amblyopia / Lazy Eye |
| <input type="checkbox"/> Strabismus | <input type="checkbox"/> Retinal Tear/Detachment | <input type="checkbox"/> Trauma / Foreign Body / Scar |
| <input type="checkbox"/> No Past Eye History | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Herpes Simplex / Zoster |
| | | <input type="checkbox"/> Recurrent Corneal Erosion |

- Past Ocular Surgery: _____
(State Which Eye)
- | | | |
|--|--|---|
| <input type="checkbox"/> PRK | <input type="checkbox"/> Muscle Surgery | <input type="checkbox"/> Cataract Surgery |
| <input type="checkbox"/> RK / AK | <input type="checkbox"/> Retinal Surgery | <input type="checkbox"/> Glaucoma Surgery |
| <input type="checkbox"/> No Past Eye Surgery | <input type="checkbox"/> ALK/ LASIK | <input type="checkbox"/> Corneal Transplant |
| | | <input type="checkbox"/> Other : _____ |

- Contact Lens History:
- | | |
|--|---|
| <input type="checkbox"/> No Contact Lenses | <input type="checkbox"/> Soft Toric |
| <input type="checkbox"/> Soft Daily Wear | <input type="checkbox"/> RGP - Years Worn: _____ |
| <input type="checkbox"/> Soft Overnight Wear | <input type="checkbox"/> PMMA - Years Worn: _____ |

Date Contacts Were Last Worn: _____ Difficulty with Contact Lens Wear? Yes No

If Yes, please explain: _____

Emergency Contact Information:

Emergency Contact: _____ Relationship: _____

Phone Number: _____ Cell Phone Number: _____

Prior to your procedure, your Eye Doctor or TLC will dilate your eyes with a pupil dilator drop. It is recommended that you have a driver if dilation drops are used. A consultation visit to TLC, to find out if you are a laser refractive candidate, does not constitute a full eye examination.

By signing below you:

1. Acknowledge that you have been informed of the Privacy Practices and Patient Bill of Rights and agree to receive emailed information, offers and promotions from TLC.
2. Acknowledge that you have access to a copy of these documents in the center.
3. Agree that all information given on this form is true to the best of your knowledge.

Signature of Patient or Personal Representative _____ Date _____

If Personal Representative, please print your name and describe your relationship to the patient