

For Internal Use Only

MR# _____



Patient Name _____

Gender [] Male [] Female Date of birth ____/____/____

Address _____

City, State, Zip _____

Primary Phone (____) _____ Please circle one: work home cell

Secondary Phone (____) _____ Please circle one: work home cell

E-mail _____

Work address _____

Emergency Contact _____ Phone (____) _____

How did you hear about EyeSight Hawaii? _____

Reason for wanting laser vision correction surgery _____

Occupation _____

Hobbies _____

Contact Lens History

Have you ever worn contact lenses? [] No [] Yes - Soft Toric Gas Permeable Hard

When did you last wear contact lenses and which type? _____

Previous monovision experience? [] Yes [] No Which eye for reading? [] Right [] Left

For LASIK Consultations

During your LASIK evaluation, Dr. Olkowski or Dr. Louie may find other eye conditions (unrelated to the vision correction surgery) that require medical care. The doctor will explain these conditions to you. If you would like EyeSight Hawaii to treat these conditions, please fill in the insurance information on the back of this page and we may be able to file a claim with your insurance carrier.

LASIK Patient's Signature _____ Date _____



Patient Name _____

Responsible Party _____ Phone (____) _____

Address _____

Primary Insurance _____

Policy Number _____

Subscriber _____ Gender [] Male [] Female

Other Insurance _____

Policy Number _____

Subscriber _____ Gender [] Male [] Female

Insurance Authorization if applicable (Not required for LASIK consultations.)

I hereby authorize my doctor to furnish information to insurance carriers of government agencies concerning my illness and treatments and I hereby assign to them all payments for medical services rendered to myself or my dependents. **I understand I am responsible for any amount not covered by insurance.**

If I am covered by Medicare, I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature _____ Date _____

Social Security Number _____