Tell Us About Yourself
TLC PATIENT REGISTRATION

TLC Laser Eye Centers®

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)

☐ Arthritis ☐ Lupus ☐ Healing Problems / Keloid Scars
☐ Diabetes ☐ Asthma ☐ HIV or other Autoimmune Disorders
☐ High Blood Pressure ☐ Depression ☐ Pregnant/Breastfeeding - or – planning to become pregnant within next 6 months.
☐ Tuberculosis (TB) ☐ Smoker ☐ Health Care Worker / Patient Care Contact
☐ Pacemaker ☐ MRSA Carrier ☐ Other :_____

EYE HISTORY :

Past Ocular History: (State Which Eye)

☐ No Past Eye History

☐ Cataracts ☐ Glaucoma, you or Family ☐ Keratoconus, you or family
☐ Double Vision ☐ Corneal Abrasion ☐ Amblyopia / Lazy Eye
☐ Strabismus ☐ Retinal Tear/Detachment ☐ Trauma / Foreign Body / Scar
☐ Dry Eyes ☐ Herpes Simplex / Zoster ☐ Recurrent Corneal Erosion

Past Ocular Surgery: (State Which Eye)

☐ No Past Eye Surgery

☐ PRK ☐ Muscle Surgery ☐ Cataract Surgery
☐ RK / AK ☐ Retinal Surgery ☐ Glaucoma Surgery
☐ ALK / LASIK ☐ Corneal Transplant ☐ Other :_____

Contact Lens History:

☐ No Contact Lenses ☐ Soft Toric
☐ Soft Daily Wear ☐ RGP – Years Worn: _____
☐ Soft Overnight Wear ☐ 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