iLaser Vision Surgery

See Us Today. See Freely Tomorrow

PLEASE COMPLETE ALL DETAILS APPLICABLE IN FULL

Personal Details

Title: ___Name:____ Date of Birth: _ _/_ _/_ _ _ _

Address: ____ Post Code: _ _ _ _

Phone: Home ____________________ Mobile:___________________ Work:_______________________

Email address: ____

Occupation /or previous occupation if retired: ____

Hobbies and Sports:____

Person to Contact (Next of Kin)

Name: _________________________ Relationship**:** __________________Phone No: __________________

Address: ____ Post Code: _ _ _ _

Medicare/Health Fund/Concessions

Medicare No: _ _ _ _ _ _ _ _ _ _ _ Valid to**:** _ _ / _ _ _ _ Ref No: _ *(Number next to your name)*

Health Fund: _________________________ Membership Number**:**_______________________________

DVA Gold Card Number: *(if applicable)* ____

Interested Health Practitioners

Please tick the box and provide the following information if you ***consent*** *to iLaser keeping your General Practitioner and/or Optometrist updated with relevant information regarding the outcome of appointments and treatment?*

☐ GP Name: ____ Suburb: ______________________________

☐ Optometrist ____ Suburb: ______________________________

Further Questions

Please tell us your reasons for attending iLaser today.____

____

How did you hear about iLaser? ____

Continued…………….

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Medical History:

Eye Condition and history: (please tick)

☐ Do you wear glasses? If yes, how long have you worn glasses for?____

☐ Do you wear contact lenses? If yes, how long have you worn glasses for?__________________________________

Do you wear them for Distance, Reading or Both?____

☐ Do you have any previous history of eye disease? (please describe)_______________________________________

☐ Have you had any major eye infection/ or eye surgery? (please describe and give approximate month and year)

____

☐ Is there a family history of eye disease/eye surgery? (please describe)____________________________________

____

General Health: (please tick)

Do you have: ☐ High blood pressure ☐ Diabetes ☐ Cholesterol ☐ Heart problems

☐ Medical allergies (please list) ____

Please add any other relevant medical history____

____

Please provide any current medication (including any eye drops)____

____

Patient Declaration:

I certify that the above information is true and correct to the best of my knowledge.

Name of patient: ____

Signature of patient:____ Date:____________________

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