The Laser Center
OF CENTRAL PENNSYLVANIA

You will see the difference.
814.867.1852
www.tlcofpa.com

NEW PATIENT REGISTRATION FORM
The Laser Center of Central PA

Please print this form, sign & date it and bring it with you to your first appointment. Thank you.

Name: ____ Preferred Name____________________
Last First MI

Date of Birth:___________________________ Age:_________ Male Female

Address:________________________________City_____________State____________Zip_________

Residency: US Canada Other Email:_____________________________

Home Phone: (___)________________ Work Phone: (___)_______________ Cell Phone: (___)___________________

Preferred Contact: Home # Cell # Work # Email

Employer:_____________________________Occupation:_________________ S.S. #______________

Emergency Contact:_________________Phone:_________________ Relationship:_______________

Eye Doctor and Coverage

Who is your Eye Doctor? ________________________Date of Last Exam:_____________________

How did you hear about us?____

Medical/Vision Insurance Provider:___________________ Vision Coverage: Yes No

To Better Understand Your Vision Needs, Please Complete The Following:

Hobbies / Sports / etc:____

How long have you been considering Refractive Surgery?____________________________________

What is your motivation for Refractive Surgery?____

What concerns do you have about having Refractive Surgery?_________________________________

If you are a candidate, would you be interested in having Refractive Surgery?____________________

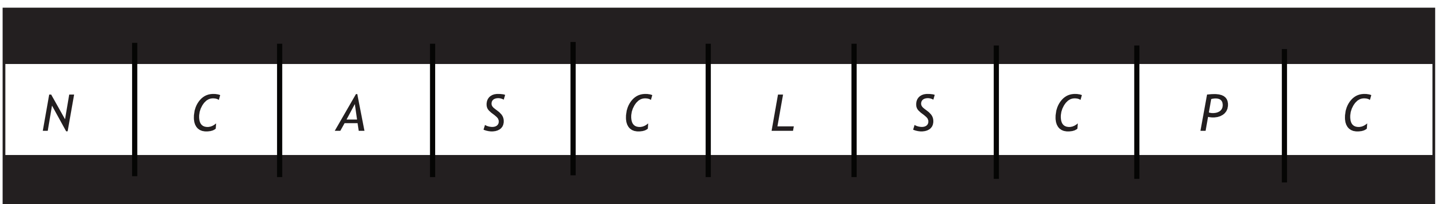
Anything else we should know?____

The Information Below is for Internal Use Only. Please Proceed to Page 2.

Candidate ___ Non-Candidate___ Reason: ICL___ Presbyopia___ Intacts___ Keratoconus___

Procedure: Lasik___ Surface Ablation___ AK___ Other_____________ (Conventional___ Custom____)

Technology: VISX___ Autonomous ____ Other:_____________ Lifetime Commitment: Yes____ No____



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The Laser Center of Central Pennslyvania
428 Windmere Drive, State College, PA 16801

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Medical Informaion

Medication Allergies: None____ List:____

____

____

Medications: None____ List:____

____

____

General Health Problems: None___ List:____

(Check all that apply)

___Arthritis ___Lupus ___Healing Problem/Keloid

___Diabetes ___Asthma ___High Blood Pressure

___HIV ___Pacemaker ___Pregnant/Breast Feeding

Eye History

Past Ocular History:
(check all that apply)

___Cataracts ___Double Vision ___Glaucoma

___Corneal Abrasion ___ Amblyopia/ Lazy Eye ___Retinal Tear/ Detachment

___Trauma/Foreign Body/Scar ___Herpes Simplex/ Zoster ___Recurrent Corneal Erosion

___No past eye history ___Strabismus ___Dry Eyes

___Keratoconus ___No Past Eye History

Past Ocular History:
(State Which Eye)

___PRK ___Muscle ___Cataract

___RK / AK ___Retinal Surgery ___Glaucoma Surgery

___ALK LASIK ___Corneal Transplant ___Other Explain ___No Past Eye History

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:____

Prior to Laser Vision Correction, your eye doctor or Nittany Eye Associates will dilate your eyes with a pupil dilator drop. It is recommended that you have a driver if dilation drops are used.

By signing below you:
Acknowledge that you have been informed of the Privacy Practices and Patient Bill of Rights.
Acknowledge that you have access to a copy of these documents in the center.
All information given on this form is true to the best of you knowledge.

____ ____________________

Signature of Patient or Personal Representative *Date*

If Personal Representative signs, please give their name (print) and describe their relationship to patient:

Download available at: www.tlcofpa.com

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