MILAUSKAS EYE INSTITUTE
LASIK PATIENT INFORMATION

Date:_____

LAST NAME _____ **FIRST NAME** _____ **MIDDLE** _____

BILLING/CURRENT ADDRESS _____ **CITY** _____

STATE _____ **ZIP CODE** _____ **HOME PHONE** _____ **E-MAIL ADDRESS** _____

EMPLOYER:_____

WORK ADDRESS _____ **CITY** _____

STATE _____ **ZIP CODE** _____ **WORK PHONE** _____ **PAGER/CELL#** _____

SOCIAL SECURITY _____ **DATE OF BIRTH** _____ **AGE** _____ **MALE FEMALE**

OCCUPATION/TITLE _____ **GLASSES/CONTACTS (CIRCLE)**

EMERGENCY CONTACT _____ **RELATIONSHIP** _____ **EMERGENCY PHONE** _____

PRESENT EYE DOCTOR:_____ **LAST EXAM:**_____

PLEASE TELL US HOW YOU FOUND OUT ABOUT US:

NEWSPAPER____ **TELEVISION____**

RADIO: The Eagle 106.9 ____ U92.7 ____ KPLM 106.1 ____ Mix 100.5 ____

TELEPHONE BOOK____ **THE WEB____**

FRIEND_____ **OTHER**_____