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 #

_____ _____ _____ MALE ☐ FEMALE ☐
SOC. SECURITY # DATE OF BIRTH AGE

_____ GLASSES ☐ CONTACTS ☐
OCCUPATION/TITLE

_____ _____
EMERGENCY CONTACT RELATIONSHIP

PRESENT EYE DOCTOR:_____ LAST EXAM_____

PLEASE TELL US HOW YOU FOUND OUT ABOUT US:

Newspaper☐ Television☐

Radio: KDES 104.7☐ KUNA 96.7☐ KPLM 106☐

Telephone book☐ The Internet☐

Friend_____ Other_____

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