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: Jammin' 99.5 **U92.7 ____** **KPLM 106.1 ____** **Sunny 103.1 ____**

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TELEPHONE BOOK____ **Online____**

FRIEND_____ **OTHER**_____