P A T I E N T   I N F O R M A T I O N   **Today's Date ___/___/___**

By completing the information below, you are giving authorization for Clear Choice and its affiliates to contact you in the future.

First Name________________________________ **Last Name** ______________________________

Date of Birth _____/_____/___ **Age** _____ **Social Security Number** ________-_________-_______

Home Address____

City____ **ST**_______________ **Zip**________________

Home Phone________________________________

Signature: ____ **Date** ___/___/___

Company Name____

Work Address____

City ____ **ST**___________ **Zip**____________________

Work Phone_________________________________

E-mail Address (if available) ____

1) Have you taken any of the following medications in the past 3 months?

Prednisone	**Yes**	**No**
Steroids	**Yes**	**No**
Acutane	**Yes**	**No**
Chemotherapy	**Yes**	**No**
Insulin	**Yes**	**No**

2) Do you have any of the following health problems?

Rheumatoid arthritis	**Yes**	**No**
Lupus	**Yes**	**No**
Diabetes	**Yes**	**No**

3) Are you pregnant or nursing?   **Yes**   **No**

4) Have you ever had any of the following eye diseases?

Keratoconus	**Yes**	**No**
Herpes keratitis	**Yes**	**No**
Glaucoma	**Yes**	**No**

5) If you wear contact lenses, please complete the following:

Soft Lenses	________________	**Last date worn**
Hard Lenses	________________	**Last date worn**
Gas Permeables	________________	**Last date worn**

6) Do you wear bifocals? **Yes** **No**

7) Have you had any experience wearing contact lenses for monovision?

Yes **No**

8) I am interested in Financing. **Yes** **No**

To assist us with our marketing, please share with us how you heard about Clear Choice Laser Eye Centers.

Please Be Specific

Direct Mail ____

Newspaper____

Radio____

My Space____

Face Book____

Television____

Billboards____

Internet____

Seminar____

Yellow Pages____

Patient Referral____

Doctor Referral____

For office use only:

OD______________________________ **OS**______________________________