

Patient Name:		DOB:	Age:
Address:		City:	Postal:
Home Phone:		Cell Phone:	
Email:			
HC:	VC:	Gender:	

Medical Hx / Allergies: _____

Comments: _____

Exam Date: _____

Present Correction

OD _____ X _____ 20/

OS _____ X _____ 20/

IOP

OD _____

OS _____

Dominant Eye

OD

OS

Slit Lamp Exam

OD

OS

Fundus Exam

OD

OS

Patient Interested in Refractive Cataract Surgery?

Yes

No

Referring Doctor:		Billing Number:
Address:		Meeting Date:
Phone:	Fax:	Surgery Date:
Email:		Comments: