THE ***COLUMBUS LASER & VISION*** *INSTITUTE*

Welcome to our office!

Please **PRINT your information on the attached forms in BLACK INK –** ***the second form has TWO SIDES*****.**

LAST: _____ FIRST: _____ MI:____ D M S W
(please circle one)

ADDRESS: _____ _____
Street Address **Apt / Lot #**

_____
City **ST** **ZIP**

PHONE #s: HOME: _____ WORK:_____ (x _____)
(A C) ### - #### **(A C) ### - ####** **(EXT)**

If applicable: **CELL: _____ Email:_____**
(A C) ### - ####

Social Security #: _____ Date of Birth: _____ Age: _____
- ## - #### **MM/DD/YYYY**

EMERGENCY CONTACT: _____ **RELATIONSHIP: __Spouse**
First & Last Name ___ Child ___Parent ___ Other *

HOME#: _____ WORK#: _____ (x _____) *_____
(A C) ### - #### **(A C) ### - ####** **(EXT)**

ADDRESS: _____
Street , State , ZIP Code

FAMILY DOCTOR: _____ PHONE : _____
Doctor's / Practice Name **(A C) ### - ####**

ADDRESS: _____
Street , State , ZIP Code

EMPLOYER: _____ **PHONE : _____**
Name **(A C) ### - ####**

ADDRESS: _____
Street , State , ZIP Code

OCCUPATION: _____

HOBBIES: _____

I agree and understand that if the results of my consultation indicate that I am a candidate for surgery, the $100 consultation fee is due on the day of my initial visit and is considered to be non refundable even if I elect to cancel, postpone or decide against treatment. This consult fee would be applied toward the remaining balance of my procedure. I understand that certain medical eye problems, diseases, and ancillary testing and/or treatments (punctual plugs, contacts, glasses, yearly exams) are not covered under the Laser Vision Correction fees**.**

_____ _____
Patient's Signature **Date**

How did you hear about Columbus Laser & Vision: _____

Thank You!