Cornea Associates of Texas

Laser Vision Correction: Patient Information

First Name: ______________________ MI: ______ Last Name: ______________________

Mailing Address: ______________________ City: __________ State: ______ Zip: ________

Home Telephone: ______________________ Date of Birth: __________ Age: ______ Sex: ______

Marital Status: __________ Social Security No.: ______________________ Email: ______________________

Employer's Name: ______________________ Position: ______________________

Address: ______________________ City: __________ State: ______ Zip: ________

Work Telephone: ______________________ Email: ______________________

Emergency Contact: ______________________ Relationship: ______________________

Home Telephone: ______________________ Work Telephone: ______________________

Referred By: ______________________

Primary Eye Doctor: ______________________ Last Seen: ______________________

Please Read and Sign Below

I hereby authorize the physicians and staff of Cornea Associates of Texas to perform procedures necessary to assess and diagnose my condition properly, and such treatments as may be prescribed by my attending physician during any and all visits to Cornea Associates of Texas. I understand that I am financially responsible for ALL charges from services rendered to me by Cornea Associates of Texas.

Signature: ______________________ Date: ______________________