



Consultation Office Location: (please check one)

13320 Riverside Dr., Ste. 114
Sherman Oaks, CA 91423
Phone: 818-501-3937
Fax: 818-980-0651

2625 W. Alameda Ave., Ste. 208
Burbank, CA 91505
Phone: 818-980-2020
Fax: 818-845-1916

1936 Huntington Dr. Ste. A
South Pasadena, CA 91030
Phone: 626-795-9793
Fax: 818-845-176

9100 Wilshire Blvd., Suite 852W
Beverly Hills, CA 90212
Phone: 866-273-3327
Fax: 818-845-1916

LASIK Consultation Request Form

Today's Date Legal Last name: Legal First name:
aka Male/Female Date of Birth:

Home/Daytime Phone () Mobile Phone () Best # to call:

Street Address: City: State: Zip:

Reasons for considering surgery/expectations/comments:

Procedure Discussed:

OU / OD / OS / MONOVISION

- Conventional/Custom LASIK IntraLASIK (All laser) PRK RLE/CLE ICL Intacs

Quoted Price \$
One Year Enhancement Included
With Lifetime Commitment

Do we need to contact patient regarding appointment?
Is the patient ready to schedule surgery?
Is patient interested in 0% financing?

Referring Doctor: Office Location (city only)

O.D. Phone: () Fax: ()

Ocular History:

Medical History:

Current Medications:

Allergies:

Contact Lens History: # of year(s) worn Daily Soft/Soft Toric/Gas Permeable (RGP) (Please circle one)

OD: 20/ Contact Lens Power OS: 20/

Examination

OD

OS

Uncorrected Visual Acuity
Current Spectacles
Manifest Refraction
Cycloplegic Refraction

(only if completed, otherwise can be performed at a later date)

Keratometry
Pachymetry (if available)

Dominant Eye:

Lids / Lashes / Lacrimal

Conjunctiva

Cornea

Anterior Chamber

Iris

Lens

C/D Macula Dilated Fundus Exam C/D Macula

Periphery

Doctor's Signature: Exam Date:

PLEASE FAX FORM TO OUR REFRACTIVE SURGERY DEPARTMENT AT (818) 845-1916.

FOR OFFICE USE ONLY: LASIK Consult Scheduled Sherman Oaks / Burbank / So. Pasadena / Beverly Hills

Initial Call Faxed to OD (initials)

Notes: