

Horizon Eye Specialists & LASIK Center

Joshua K. Duncan, D.O.

John B. Cason, M.D.

Name: _____ Date of Birth _____

Emergency Contact Information

Name: _____ Phone: _____ Relation to Pt: _____

Who may we thank for referring you to our office?

Optometrist Name: _____

Friend/Family Member: _____

Printed Ad Radio Internet Mailer Television

Other: _____

What are the three most important factors to you pertaining to your LASIK surgery?

Have you ever been told you were a good candidate for LASIK? ☐ Yes ☐ No

If yes, by whom? _____

What is the most exciting thing you are looking forward to doing without the aid of contacts or glasses? _____

Please list any allergies or medical conditions/surgical history that the surgeon should be aware of:

Are you currently pregnant or nursing? ☐Yes ☐No

Are you sensitive to any of the following:

<input type="checkbox"/> Iodine	<input type="checkbox"/> Dyes/Perfumes
<input type="checkbox"/> Tapes	<input type="checkbox"/> Latex

Have you ever had an adverse reaction to narcotic medication? ☐Yes ☐No

If yes, please explain: _____

The above information is accurate and complete to the best of my knowledge:

Patient Signature

Date _____