TEKWANI VISION CENTER

OPHTHALMOLOGY
OPHTHALMIC and LASIK SURGERY

9911 KENNERLY RD
ST. LOUIS, MO 63128
(314) 842-2020

5805 CHIPPEWA
ST.LOUIS, MO 63109
(314) 481-2020

5770 Mexico Rd, Ste. D
ST. Peters, MO 63376
(636) 697-5858

Name_____
(First) (MI) (Last)

Address_____
(Street) (City) (State) (Zip)

Phone (Home)_____(Cell)_____(Email)_____

Date of Birth ____/_____/_____ Age _____ Sex: M F Social Security Number _____

Language _____ Race _____ Ethnicity _____

Occupation_____ Employer_____

Please check one: Single____ Married____ Widowed____ Divorced____

Next of kin/Emergency Contact _____Phone_____

Who referred you to our office? _____

Primary Care Physician _____ Phone # _____

Pharmacy name and phone number_____

Insurance Information: **(Please Provide Insurance Card to the Front Desk)**

Primary Insurance Name _____

Insurance Policy Holder's Name_____ Date of Birth ____/_____/_____

Insurer's Social Security (if different from above)_____

Secondary Insurance Name _____

When was your last professional eye exam and by whom?

Date_____

Name of Doctor/Location _____

Do you wear glasses? □ Yes □ No
Do you wear drug store readers? □ Yes □ No
Do you wear contact lenses? □ Yes □ No
If yes, what type? □ Soft □ Gas permeable □ Monovision □ Bifocal contacts

Have you ever had any eye surgery or eye injury (i.e. LASIK, Cataract, Retinal Surgery, etc.)?

□ Yes □ No

If yes, what kind of surgery/injury? Which eye? When?

_____

_____

Do you currently use any eye medications (over the counter or prescription)?

□ Yes □ No
If yes, please list _____

What brings you in to see us today?

_____

_____