Dr. Nader G. Iskander, M.D.

PATIENT REGISTRATION

Today's Date:____________ Patient Gender: ☐Male ☐Female Social Security:_____-_____-_______

Name: Dr., Mr., Mrs., Ms.______________________________Date of Birth:____________Age:________

(First) (MI) (Last)

Address:___________________________City:____________________State:____________Zip:_________

Home Phone:______________________Work Phone:__________________Cell Phone:______________

Email Address:____

Employer:____________________________________ Occupation:______________________________

Marital Status: ☐S ☐M ☐W ☐D Emergency Contact:_________________Phone #:______________

How long have you been considering laser vision correction? __________________________________

Who is your Optometrist? ____

Did you visit our website at www.mysaeyes.com prior to choosing San Antonio Eye Specialists? YES☐NO

How soon are you looking to have laser vision correction surgery?______________________________

1 week ☐2 weeks ☐1 month ☐6 months ☐1 year ☐Other ______________________

What hobbies do you like to do that glasses and contact lenses hinder you from fully enjoying?

(such as movies, swimming, skiing, night driving, etc.):_____________________________________

Do you know some one that has had laser vision correction with San Antonio Eye Specialists? YES NO

How did you hear about San Antonio Eye Specialists?

Previous Patient, who? ____

☐ Internet Search Engine: ☐ Google ☐ Yahoo ☐ Other: __________________

☐ Referring Doctor, who? ____

☐ San Antonio Eye Specialists Website Other: _________________

Radio, which station? KAJA 97.3 | MAGIC 105.3 | KISS FM 99.5 | THE EAGLE 106.7

KONO 101.1 | Y100 100.3 | KZEP 104.5 | JACK-FM 102.7 | KKYX 680 AM

For medical purposes of the practice, please provide us with your ***medical*** insurance information below.

PRIMARY INSURANCE INFORMATION

Primary Insurance:______________________________Policy Holder: ____________________________

Policy Holders Social Security #:______________________________Date of Birth:_________________

ID/ Policy#:_______________________Group #:_____________________________Co-Pay:___________

SECONDARY INSURANCE INFORMATION

Secondary Insurance:____________________________Policy Holder: ____________________________

Policy Holders Social Security #:______________________________Date of Birth:_________________

ID/ Policy#:_______________________Group #:______________________Co-Pay:__________________

____ ______________________________

Patient Signature Date

YOUR EYE HEALTH

Nader G. Iskander, M.D.

for your eyes...don't compromise!
SAN ANTONIO EYE SPECIALISTS

Patient Name: ______________________ Date of Birth: ____________________

When was your last exam? ____

How old are your glasses? ____

Do you currently have trouble with bright lights of night vision? ___ Yes ___ No

Do you wear contact lenses? ___ Yes ___ No

If so, what type of contacts? ___ Soft ___ Toric ___ Hard ___ Rigid Gas Permeable

___ Disposable ___ Daily Wear ___ Extended Wear (Sleep in lenses)

Have you ever had a corneal abrasion or erosion? ___ Yes ___ No

Have you been treated for dry eye? ___ Yes ___ No

Have you ever had any surgery, injuries, or laser treatments to the eye? ___ Yes ___ No

If yes, please list: ____

Please list any eye drops you are presently using: ______________________________

MEDICAL HISTORY

Do you have or have you ever been treated for the following?

___ Stroke	___ Ulcer	___ Heart Disease
___ Seizure	___ Stomach Disorder	___ Heart Attack
___ Brain Tumors	___ Digestive Disease	___ Bypass Surgery
___ Other Brain or Nerve Disorders	___ Hepatitis B or C	___ Other Heart Disease
___ Asthma	___ Liver Disease	___ High Blood Pressure
___ Emphysema	___ Autoimmune Disease	___ Other Blood Vessel Disorder
___ Pneumonia	___ Arthritis	___ Keloids
___ Other Lung Disorders	___ Kidney Stones	___ Currently Pregnant or Nursing
___ Tuberculosis	___ Kidney Infection	___ Other: ____________
___ Prostate Disease	___ Nephritis	___ Cancer/Tumor, Type: ____________

Diabetes, if so, how long? ______________________ Are you currently using Insulin? ________

___ Autoimmune, or immunodeficiency disease (e.g., Rheumatoid Arthritis, Lupus, or HIV)

___ Keratoconus (a corneal disease) or have any other conditions that cause thinning of the cornea

___ Corneal Transplant ___ Herpes eye infections

___ Take Accutane for acne treatment ___ Double Vision

___ Take Cordarone or Imitrex for controlling normal heart rhythm

FAMILY MEDICAL HISTORY

Is there a family history (parents and/or siblings) of the following:

___ Cataracts ___ Glaucoma ___ Retinal Disease ___ Diabetes ___ Blindness ___ Strabismus (Lazy Eye)

___ Keratoconus ___ Corneal Transplant ___ Other corneal diseases ______________________

Medications you are ALLERGIC to: ______________________________________

Medications you are CURRENTLY taking, including over the counter: ______________________

____

List any surgeries you have had: ______________________________________

Patient Signature ______________________________ Date ______________

San Antonio Eye Specialists: 2810 N Loop 1604 W, Ste. 200, San Antonio, Texas 78248, Phone (210) 822-9800, Fax (210) 822-9810