STOKES VISION CORRECTION CENTER
602 E. Cheves St. Florence, SC 29506
(843) 664-2127

Name: Date:

Social Security Number :

Occupation: Eye Color:

Referral Information

Did your doctor refer you to have refractive surgery? Doctor's Name	☐ Yes	☐ No
Did a patient refer you to have refractive surgery? Patient's Name	☐ Yes	☐ No
What source helped you to choose Stokes Eye Clinic?	☐ Website ☐ Newspaper Ad ☐ Seminar ☐ Radio Ad ☐ Television ☐ Other (please specify)	
Where do you currently obtain your eye care?		
Date of last eye exam?		
What is the primary reason you are interested in having refractive surgery?		

Activities and Interests

☐ Golf	☐ Running/Walking	☐ Movies
☐ Tennis	☐ Dining Out	☐ Books/Reading
☐ Biking	☐ Gardening	☐ Museums/Arts
☐ Skiing	☐ Theatre	☐ Travel
☐ Dancing	☐ Family/Kids	☐ Other (please specify)

Authorization for Release of Information

I hereby authorize Stokes Regional Eye Center to release any medical information to my referring physician or insurance company. I further understand that I can withdraw this consent for release of information at any time prior to this expiration date except to the extent that action has been taken in reliance hereon.

Signature Date

For Office Use Only: Chart #: