Schwartz Laser Eye Center

Patient Name _____ **Date of Birth** _____/_____/_____

Allergy	**Reaction** (skin rash, hives, itching, fever, swelling, runny nose, shortness of breath, ect.

Medication (Rx, over the counter, herbals, vitamins, mineral, dietary (nutritional) supplements, ect.)	**Strength**	**Frequency**	**Form of Medication** (liquid, capsule, tablet, inhalant, injection, drop, ect.)

PHARMACY:	**Phone:**	**Location:**

Doctor Name	**Physician type** (PCP, Cardiologist, Retina, Endocinologist, ect.)	**Practice Name / Location**	**Phone Number**

Patient Signature: _____ **Date:** _____

Confirming Doctor's Signature: _____ D.O. / O.D. Date: _____
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Jay L. Schwartz, D.O. Kevin Donausky, O.D. Marc Bloomenstein, O.D. Kristi Rhodes, O.D.