

# WEST POINT REFRACTIVE SURGERY PROGRAM

## ADMINISTRATIVE DATA

Patient Name: \_\_\_\_\_ Rank: \_\_\_\_\_ SS#: \_\_\_\_\_

Branch of Service: \_\_\_\_\_ Unit/Company: \_\_\_\_\_ Occupation (MOS): \_\_\_\_\_

Are you an aviator / on flight status or receive flight pay? \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F

What is your eye color? (circle one) Blue Brown Hazel Other: \_\_\_\_\_

Phone Numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

AKO Email Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
PRINTED NAME