444 Western Boulevard
Jacksonville, North Carolina 28546-6816 Phone
(910) 455-1221

Coastal Carolina Community College

Eye Examination Form

Patients Name: _____
Last First M.I.

Address: _____
Street/P.O. Box

_____
City State Zip

Phone: _____ **Date of Birth:** _____/_____/_____

Visual Acuity:

Slit Lamp:

Fundi: Dilated_____

Color Blindness:

Please circle one: *Conditions* ***do exist*** *or* ***do not exist*** *in the patient's eyes which would prevent the student from observing laser surgery given the proper eyewear.*

Signature: _____ **Date:** ____/_____/_____
M.D./ O.D.

An Equal Opportunity Employer

Revised: 6/4/2025