WELCOME BACK TO THE PROFESSIONAL EYE CARE CENTER!

Thank you for allowing us to continue serving your eye care needs. Please help us to keep your file current by completing the following:

Today's Date: _____

Name_____
(Last) (First) (Middle)

___I have reviewed my address, phone numbers and employment information that is currently on file with the front desk staff and nothing has changed.

Please indicate changes/updates:
Address_____
City/State/ZIP_____
Telephone (home)_____(work)_____(cell) _____
Employer_____Occupation_____

Are you interested in any specific type of contact lens? Please check:

___Soft disposable ___1-day disposable
___Gas permeable ___Astigmatic soft lenses
___Lenses that change eye color ___Bifocal contact lenses

Are you interested in learning more about laser vision correction? ___Yes___No

Please list any changes in your hobbies, sports and special interests: _____
_____

If you wish to receive our monthly newsletter by email, please provide your current email address. This is for information purposes only and is never given to any other party:
_____

OFFICE POLICY

It is customary to pay for all services as they are rendered. Please be prepared to pay all co-payments today with cash, check or charge. There is a $25.00 billing fee if the exam co-payment is not paid today. There is a $35.00 fee for returned checks.

Professional fees for services, spectacles and contact lenses are non-refundable.

Whenever possible, kindly give 24 hrs. notice when canceling appointments.

Signature_____