INTERESTED IN LASIK?

LASIK INTEREST FORM

Complete this form and return to your eye doctor.

Today's Date: _____ Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Email Address: _____ Date of Birth: _____

Name of Eye Doctor: First _____ Last: _____

Please select the statement that better describes you:

- ☐ Let me know if I'm a candidate for LASIK
- ☐ Send me an informational brochure about LASIK

Doctor office use only:
Fax to Specialty Eye Institute (517) 817-0141
Practice Name: _____ Location: _____
Referring Physician Name: _____
Affiliate Phone: (866) 399-1790

SPECIALTY EYE INSTITUTE