Print Form

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Medical Director

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Phone (970)424-5555
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Date _____

Initial Interest Form (form a)

----------Patient Information----------

Legal First Name _____ M.I. _____ Last Name _____

Date of Birth_____ Age_____ Marital Status: _____

Mailing Address_____ City _____ State _____ Zip _____

Physical Address (if different than above)_____ City_____ State _____ Zip _____

Home Phone _____ Work # _____

Cell Phone# _____ E-Mail Address _____

Occupation _____

Prescription _____ Vision Coverage? Y/N _____

Other _____

----------Doctor Information----------

Doctor _____ Contact Person _____

Address _____ City _____ State ____ ZIP _____

Phone with Area Code _____ FAX _____

----------Additional Information----------

Please indicate with an X which of these topics have been discussed:

Custom LASIK ____ Conventional LASIK _____ Monovision _____ Reading Glasses _____

Cost _____ Other _____

Timeframe for surgery ASAP _____ 3-6 Months _____ Next 12 months _____ Not Sure _____

Other _____

Why is patient considering LASIK?

_____

_____