LASIK INTEREST CARD | COMPLETE AND RETURN TO YOUR EYE DOCTOR

TODAY'S DATE: ____________ ◌ Mr. ◌ Ms. NAME: ______________________________

ADDRESS: ____

CITY: ____________________ STATE/PROVINCE: ____________ ZIP/POSTAL CODE: ____________

DAYTIME PHONE: ____________________ ◌ Cell ◌ Home ◌ Work

E-MAIL 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.

Truly Life Changing MOMENTS

Fax to TLC Laser Eye Centers
Coral Gables
Fax # 305.461.9633

Practice/Doctors Name

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RE#555555

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