

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
