



International Eyecare Center

Lasik Center • 2445 Broadway • Quincy, IL 62301 • 217-222-8800

PLEASE Complete prior to your appointment

Welcome to IEC!

We will be with you shortly to discuss your eligibility for participation in the Lasik /CK program. If you qualify, we will explain the steps that we need to take to schedule your procedure.

Date _____

Please Print

Form with fields for Last Name, First Name, Middle Initial, Social Security #, Date of Birth, Age, Marital Status, Sex (M/F), Current Street Address, City, State, Zip, Home Phone Number, Work Phone Number, Cell Phone Number, Employer, Occupation, Spouse / Significant Other's Name, Name of Person To Contact In Case Of Emergency, Daytime Phone Number, Relationship.

HOW DID YOU HEAR ABOUT US?

Form with fields for Friend/Relative, TV, Radio, Newspaper, Other, and their respective details like station or name.

Form with questions about glasses and contact lenses: How long have you worn glasses?, How old are your current glasses?, Do you wear contact lenses?, How long have you worn contact lenses?, How often do you purchase contact lenses?, How often do you purchase glasses?, How often do you purchase contact lens solution or eyeglass cleaner?, How often do you go to your optometrist/ophthalmologist?



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Have you inquired about Lasik /CK with other providers? Yes _____ No _____

Practice Name _____ Date _____

How committed are you to having the Lasik /CK procedure?

VERY _____ My eyecare practitioner recommended Lasik /CK for me _____ I'm just thinking about it _____

What would be an ideal date for your procedure to be scheduled? _____

List three of the most important reasons you would like to have this procedure:

(include your hobbies and/or interests)

Is your spouse/significant other totally supportive in your desire to have Lasik /CK? Yes _____ No _____

Do you live in an environment where others wear glasses or contacts? Yes _____ No _____

(indicate with check mark or number next to relative)

Spouse _____ Son _____ Daughter _____

Father _____ Mother _____ Brother _____ Sister _____

I attest that all of the information above is correct to the best of my knowledge. I understand that payment is expected in full prior to the day of my procedure. I understand I am financially responsible for all services rendered at IEC and its affiliates.

Please note: we do not accept personal checks on the day of your procedure.

Patient Signature: _____ **Date:** _____