Appointment Check-In

Patient First Name: ______________________ Patient Last Name: _____________________

Email is now an important tool we use to help communicate with our patients. To help us provide the most prompt service and current promotions possible, please enter your email address below:

Patient Email Address: ____

Primary Care Physician: ____

Primary City, State: ____

Pharmacy: ____

Pharmacy Address: ____

Pharmacy Phone Number: ____

Consent to Contact

You agree, in order for us to service your account and collect monies you may owe, Keelan Eye Care, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by using any email address on your account. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing services, as applicable.

I/We have read this disclosure and agree that Keelan Eye Care and it's employees may contact me/us as described above.

____________________________________	____________________
PRINT Patient Name	**Date**
____________________________________	____________________
Patient Signature	**Date**