Vision of Hope Mission: Date_____

First Name_____

Last Name_____

DOB:_____Phone_____

____

Address_____

__ City_____State_____Zip

I understand that today's visit is for the sole purpose of obtaining a new glasses prescription and new eye glasses. I understand that if a medical diagnosis is made today, the Eye Clinic, Doctors & Vision of Hope is under no obligation to follow up on any treatment.

Signature _____ Date_____