

Please save the form on your computer before filling it out.

# Welcome!

## Personal information

Mr. Ms.

Family name:

Given name:

Street:

Zip code/city:

Date of birth:

Tel home:

Mobile:

Tel office:

E-mail:

Newsletter per E-mail: Yes No

Sport/hobby:

Profession:

Referred / Recommended by:

Main reason for an optometric check-up at sehzentrum rapperswil:

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Are you undergoing medical treatment?

ophthalmologist    paediatrician    osteopathy    homeopathy    other

I wear:

glasses    contact lenses

My last check-up with an eye doctor:

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I hereby consent to the following terms and conditions:\*

Yes    No    Date:    Signature:

\* Terms and conditions:

- Please give at least 24hours notice if you wish to cancel or alter your appointment.  
Late cancelation, changes or missed appointments may be charged according to the original time reserved.
- If relevant, check with your health insurance provider to what extent costs are covered.
- Permission to share necessary information with doctors or therapists.
- Exchange of data between our branches as required.

