

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

Last eye exam: date \_\_\_\_\_ by \_\_\_\_\_

Last time pupils were dilated for retina exam: \_\_\_\_\_ by: \_\_\_\_\_

**How did you hear about Dr. Caster?**

\_\_ Physician name \_\_\_\_\_

\_\_ Other health care provider name \_\_\_\_\_

\_\_ Friend/family name \_\_\_\_\_

\_\_ Our website (www.drcaster.net or www.drcaster.com)

\_\_ Other website \_\_\_\_\_

\_\_ Yellow Pages or other directory \_\_\_\_\_

\_\_ Other \_\_\_\_\_

**May we contact you regarding specials, new products, etc?** Yes No

Email address: \_\_\_\_\_

**Are you interested in any of the following:**

\_\_ BOTOX for facial lines, spasm or under arm sweating

\_\_ Fillers for facial lines or lip enhancement

\_\_ Facial skin care

\_\_ Droopy lids or brows

\_\_ Facial skin lesions (bumps, growths, spots, etc)

\_\_ Enhancing eyelash growth