Millennium Eye Center

Patient's Name:	Today's Date:
Patient DOB:	Email:

OFFICE SIGNATURE CONSENT FORM

Your signature below acknowledges that you have received the Notices, understand, and agree with the policies outlined in our patient check-in form.

☐ I have read and understand the statements on the online check-in form. I am signing it voluntarily.

_____	_____
Patient/Representative Signature	Date

For under age 18, a parent, guardian or representative must sign. If you are signing as a representative of the patient, please indicate your relationship.

_____	_____
Representative Printed Name	Relationship to Patient

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