Name:_____DOB:_____Date:_____

Mail to: New England Vision
1100 Hinesburg Road
South Burlington, VT 05403

Or Email to: techinfo@vteyelaser.com *
Or Bring with you at your next exam

My Medications:

Medication Name Include vitamins & herbal supplements	**Dosage** Ex. 10 mg	**Route** Ex. mouth, nasal, topical	**How Often** Ex. 1 each AM, 1 in AM and 1 in PM

*** Notice: Unencrypted e-mails could be read by a third party.**