Marciano Family Vision Wellness Form

Name _____ Temp _____

Do you have a cough?

Yes ○ No ○

Do you have a fever now or have you in the past 14-21 days?

Yes ○ No ○

Have you come in contact with any confirmed COVID-19 positive patients in the last 14 days?

Yes ○ No ○

Are you experiencing shortness of breath or difficulty breathing?

Yes ○ No ○

Are you experiencing other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?

Yes ○ No ○

Have you experienced recent loss of taste or smell?

Yes ○ No ○

Have you taken a COV-19 test and have not received the results at this time?

Yes ○ No ○

Have you tested positive for COV-19 and have yet to re-test for a negative result?

Yes ○ No ○

Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)

Yes ○ No ○

Signature _____ Date _____

RETURN POLICY

No refund will be made on professional services or procedures, including comprehensive eye examinations, refractions, contact lens examinations, and medical office visits. Also, there are no refunds on customized prescription eyeglasses, including frames and lenses. All lenses are customized for you and can be remade if there is a doctor prescription change, but no refund will be given. Any unopened boxes of contact lenses can be exchanged if your prescription changes, within a year of the purchase.

Name (Print)_____Signature:_____Date:_____