Beitman
Laser Eye Institute

CoMP Care™ Program

Information Request

Doctor or Office Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Date: _____/_____/_____

Information Requested:

1. Patient Education Packets ☐
2. Patient Education Video ☐
3. IntraLASIK Brochures ☐
4. IntraLASIK Mini CD ☐
5. LASIK Brochures ☐
6. CoMP Care Pre-Op Forms ☐
7. CoMP Care Post-Op Forms ☐
8. Pre & Post-Op Envelopes ☐

Please send via fax, 248-855-7721, and/or mail:

Beitman Laser Eye Institute
5813 W. Maple Road, Suite 137
West Bloomfield, MI 48322

Thank You!