

Jeff Weltmer, O.D., P.A.
Kevin Crawford, O.D.

Welcome To Our Office

Please take a moment to answer the following questions for our records.

Date:_____

NAME:_____ DOB:_____

ADDRESS:_____ CITY_____ STATE:_____ ZIP:_____

HOME PHONE:_____ WORK:_____ CELL:_____

SOCIAL SECURITY NUMBER OF PATIENT OR PARENT IF MINOR:_____

PLEASE CIRCLE: SINGLE MARRIED DIVORCED WIDOWED

EMPLOYER:_____ OCCUPATION_____

FAMILY DOCTOR:_____ LAST VISIT/EXAM:_____

PREVIOUS OPTOMETRIST:_____ LAST EXAM:_____

SPOUSE OR PARENT NAME:_____ DAYTIME PHONE:_____

VISION INSURANCE:_____ ID #:_____

MEDICAL INSURANCE:_____ ID #:_____

This office does NOT bill for professional service. Payment is due today.

I will be paying today by: Cash_____ Check_____ Visa/MC/Discover_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any and all services rendered and materials supplied. I have read all the information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

SIGNATURE OF PATIENT OR PARENT:_____ DATE:_____