Welcome to Dr. Alethea L.H. Wessner Office

Patient Information

Patient Status : __Single __ Married __ Divorced __Widowed __Separated __ Other

Last Name _____ Maiden Name(if applicable)_____

First Name_____ Middle Initial _____Nickname_____

___Male ___Female DOB_____/_____/_____

Address_____Apt#_____

City_____ State_____ Zip Code_____

SSN#_____-_____-_____(used solely for insurance coverage)

Home Phone (_____)_____Cell Phone (_____)_____ ___text ___no text

Work Phone (_____)_____ext._____

Email _____

Occupation _____ Employer_____

Spouse/Guardian_____ Phone#(____)_____Relationship_____

Alternate Contact_____ Phone#(_____)_____Relationship_____

Family Doctor_____ Phone#(_____)_____ Fax# (_____)_____

I understand that I will be held responsible for the services I will be receiving. I further understand that payment is due at the time of services. I authorize payment of medical benefits to the physician or supplier for services rendered. I authorize the use of this form for all my insurance submissions, the release of information on all my insurance carriers, Dr. Wessner's office to act as my agent in helping me to obtain payment from my insurance carriers, and a copy of this authorization to be used in place of the original.

The contact Lens Fitting/Evaluation (if applicable) provides you with all of the diagnostic contact lenses needed for your prescription to be finalized. The follow-up appointments related to your contact lenses are inclusive with this fee. Professional Service Fees, including the examination charges and contact lens fitting fee, are **Non-Refundable**.

Signed_____ **Date** _____
Patient or Responsible Party

OFFICE USE ONLY

Vision Insurance
Insurance Name_____
Insurance ID#_____
DOB/Zip Code_____
Insured's Name_____

Medical Insurance
Insurance Name_____
Insurance ID#_____
Group#_____
Insured's Name_____

Secondary Vision
Insurance Name_____
Insurance ID#_____
DOB/Zip Code_____
Insured's Name_____

Secondary Medical Insurance
Insurance Name_____
Insurance ID#_____
Group#_____
Insured's Name_____