

Welcome to our Office!
Drs. Davis & Wiessner

Whom may we thank for referring you to us? _____

Patient Name _____ Age _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Soc Sec # _____

Employed by _____ Occupation _____

Bill Payer Information: If you are not personally responsible for this account, please give us the name of the person who is and how they are related to you: _____
Relationship to you _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Soc Sec # _____

Employed by _____ Occupation _____

PAYMENT POLICY: Payment is expected when services are rendered. Charges not covered by insurance should be paid before eyewear is delivered.

INSURANCE: If you like, we will be happy to submit your claim to your insurance company. If so, you will need to read and sign the release and authorization statements below:

I hereby authorize payment directly to either Dr. Steven J. Davis, or Dr. Harry Wiessner of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctors to release the information required to secure the payment of benefits. I further authorize the use of this signature on all insurance submissions.

Patient signature Date