ASHWORTH
VISION CLINIC
Dr. Barbara A. Scheetz
Dr. Todd R. Pietig
Doctors of Optometry

Welcome to our practice

Thank you for selecting this office for your eye care needs.
Please provide us with the following information so that we can serve you more efficiently.

Patient Information

Name _____ Birthdate _____ Sex ☐ M ☐ F

☐ Minor ☐ single ☐ married ☐ Other Preferred Pharmacy _____

Mailing address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Text ok? ☐ Y ☐ N

Employer _____ Occupation _____ Business Phone _____

Email _____ How did you hear about us? _____

If patient is a Minor

Person responsible for account _____

Relationship to Patient _____ Birthdate _____ Soc. Sec #_____

Address _____ City _____ State _____ Zip _____

Responsible party employer _____ Occupation _____ Business Phone _____

Primary Insurance

Insured Name _____

Relationship to Patient _____ Birthdate _____

Insurance Company _____

Subscribers ID# _____ Group # _____ last four of social # _____

Additional Insurance (if applicable)

Insured Name _____ Relationship to patient _____ Birthdate _____

Insurance Company_____

Subscribers ID# _____ Group # _____ last four of Social #_____

I hereby authorized payment of benefits to the above doctors for all insurance benefits otherwise payable to me for 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 authorized the above doctors to release any information required to secure the payment of benefits. I authorized the use of this signature on all insurances submissions.
I understand that I am responsible for any and all collection fees and interest charges due to failure to pay.

_____ _____
Signature of Responsible Party Date