



**Lifetime
Eyecare Center**
OF MIDDLETON • You'll Like What You See.

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(608) 831-2033

WELCOME TO OUR OFFICE
(PLEASE PRINT)

Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Home Telephone: _____
Work Telephone: _____
Date of Birth: _____
Driver's License #: _____
Email Address: _____

DATE _____

WHOM MAY WE THANK FOR RECOMMENDING US?

Friend or relative. Who? _____
Another health care practitioner. Who? _____

Yellow Pages...Which directory? _____
Newspaper ad? _____ Radio ad? _____
Civic group or community event. Which? _____
Previous patient. Who? _____
Other: _____

Employer: _____
Employer address: _____
Occupation (or in grade school): _____
Spouse (or parent's name): _____
Spouse work phone: _____
Do you participate in a flexible spending account? _____

INSURANCE INFORMATION

Primary insurance co. name: Medical _____ Vision _____
Secondary insurance co.: _____
Insurance co. address: _____
Insured's ID #: _____ Group Plan #: _____
Primary policy holder's name: _____ Relationship to patient: _____
Primary policy holder's address: _____

In case of emergency who should we contact?: _____
Day telephone: _____ Night telephone: _____
Address: _____
Relationship: _____

