**Dr. William Fleischmann, O.D**
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**Rio Linda, CA. 95673**
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## Welcome to Our Office

Thank you for choosing our practice for your eye care needs. It is our objective to provide you with the finest vision care possible. If at any time you have any questions, please feel free to ask us.

**Date:** _____ **PATIENT NAME:** _____ **DOB:** _____

**Address:** _____ **City, State, Zip** _____

**Phone #:** _____ **EMAIL:** _____

**Name of Employer:** _____ **Occupation:** _____

**Primary Vision Insurance:** □ Vision Service Plan (VSP) □ Eyemed □ Davis Vision
□ Medical Eye Services □ Spectera □ Medi-Cal □ Other: _____

**Primary Member of Vision Insurance:** _____ **Relationship to Patient:** _____

**Primary Member SSN:** _____ **DOB:** _____

**Do you have secondary vision insurance:** □ Yes □ No **If yes please fill out the following:**

**Secondary Vision Insurance:** □ Vision Service Plan (VSP) □ Eyemed □ Davis Vision
□ Medical Eye Services □ Spectera □ Medi-Cal □ Other: _____

**Secondary Member of Vision Insurance:** _____ **Relationship to Patient:** _____

**Primary Member SSN:** _____ **DOB:** _____

**Medical Insurance:** □ Anthem Blue Cross □ Blue Shield □ Kaiser □ Healthnet
□ Medicare □ Molina □ United Healthcare □ Other: _____

**Primary Member of Medical Insurance:** _____ **Relationship to Patient:** _____

**Primary Member SSN:** _____ **DOB:** _____