**Dr. Randall G. Melchert, O.D.**
Doctor of Optometry
12750 West Capitol Dr.
Brookfield, WI 53005
(262) 781-2020/Fax (262) 781-6535

**WELCOME TO OUR OFFICE!** Today's Date_____

Name _____Date of Birth_____

Home Address_____ Phone( )_____

City_____State_____ZIP_____

If minor, name of parent_____

Social Security #_____Driver's License #_____

Place of Employment_____Phone( )_____

Name of Spouse_____

Place of Spouse's Employment_____

Person Responsible for Payment of Account: Relationship_____

Name/Address (if applicable)_____

Former Eye Care Practitioner_____

Date of Last Vision Exam_____

Are you allergic to any medications? Yes_____No_____Type_____

Whom may we thank for referring you to this office?_____

His/Her Address_____

Signature_____

Family Members Who Need Eye Care:

_____

_____

_____

_____

_____

***Please inform our receptionist if you have any vision or major medical insurance that may cover today's visit.**