Drs. William & Chris Ratcliff

WELCOME BACK TO OUR OFFICE

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD(S)

Name: _____ **Date:**_____

Current Address:_____

Phone:_____ Insured Name:_____

Insurance:_____ Insured DOB:_____

Preferred Pharmacy:_____Location:_____

LIST ANY COMPLAINTS WITH YOUR EYES OR GLASSES/CONTACTS:

_____

_____

DOES ANY ONE IN FAMILY HAVE/HAD THE FOLLOWING:

Diabetes Y N Relationship:_____

Glaucoma Y N Relationship:_____

Macular Degeneration Y N Relationship:_____

CURRENT MEDICATION AND EYEDROPS:

_____ _____

_____ _____

_____ _____

Are you interested in wearing contact lenses: Y N
Do you work on a computer for an extended period of time: Y N
Would you like information regarding LASIK SURGERY: Y N

Dr's. Initials:_____