TRI-STATE EYE CARE CENTER, LTD.
Dr. William L. Ratcliff & Dr. Chris A. Ratcliff
Drs. of Optometry

Adult & Pediatric Eye Care | Specializing in Contact Lenses & Low Vision Services | Pathological Diagnosis & Treatment

WELCOME TO OUR OFFICE

Please complete the following questionnaire. This will become part of your office record and will be held in strict confidence.

Mr. Mrs.
Miss Dr. Last Name _____ First Name _____ MI ____ Date _____

Patient Information

Mr. Mrs.
Miss. Dr. _____
Home Address _____
City _____ State _____ Zip _____
Home Phone _____ Business Phone _____ Cell Phone _____
Date of Birth _____ Social Security # _____
Employer / School _____
Nickname _____

❑Same as above

Party Responsible for Payment

Name _____ Address _____
City _____ State _____ Zip _____
Home Phone _____ Business Phone _____ Cell Phone _____
Date of Birth _____ Sex: ❑Male ❑Female Hobbies: _____
Social Security # _____ Employer _____

Occupation _____ Referred By _____
Your relation to referer _____ Medical Doctor _____

1st Insurance Company	Policy #	Group #	Insured's Name
2nd Insurance Company	Policy #	Group #	Insured's Name

I agree to be responsible for any charges for services and materials supplied by Tri-State Eye Care Center, Ltd., and its Doctors for the above named patient.

_____ _____
Signature of Party Responsible for Payment Date