

General Patient Information

Full Name: _____ Birthdate: _____ SSN: _____

Spouse/Parent's Name: _____ Marital Status: Single

Married

Address: _____

Widowed

Divorced

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation: _____ Employer (self & spouse): _____

Who is responsible for this account? _____

Preferred method of payment: Cash Check Visa/Master Card/Discover

Major Medical Insurance Co: _____ Vision Insurance: _____

Please check (✓) if you have: Medicare Medicaid Other

Whom may we thank for referring you? _____

Please note reason for your visit: _____

Approximate date of your last eye exam: _____

The exam fee and 50% of any material cost (after deducting any vision benefits payable to the office) must be paid before ordering. The remaining balance is due at the time the materials are delivered.

ALL ACCOUNTS 30 DAYS PAST DUE will be charged a \$2.00 monthly service fee. If an account is turned over for collection, the patient is also responsible for collection costs and fees.

If you have vision insurance please note that it is your responsibility to verify with your insurance company that your eligible for coverage at the time of service.

*** If you have Medicare or Insurance, then please read carefully and sign below!**

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to Dr. R. Todd Ragan, O.D. Also, I authorize payment of medical benefits to be made either to myself or on my behalf to R. Todd Ragan, O.D.

Signature

Medical or Insurance #

Date