General Patient Information

Full Name: _____ **Birthdate:** _____ **SSN:** _____

Spouse/Parent's Name: _____ **Marital Status:** ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Address: _____

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