DR. STEVE RATTY
OPTOMETRIST

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PATIENT FORM

For faster service, please complete the following form prior to arriving at our office.

PATIENT INFORMATION

Appointment Date

Patient's Name

If child, Parent's Name

Street Address

City State Zip

Home Phone Work Phone Email

Birth Date Gender SSN

Employer Occupation

Spouse's Employer Spouses Work Phone

Health Insurance Carrier Policy No.

Medicare/Medicaid Policy No.

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

Method ☐ referral ☐ direct mail ☐ online ad
☐ yellow pages ☐ print ad ☐ search engine
☐ other

AUTHORIZATION

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due at the time services are rendered.

Signature _____ Date _____