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 ____ Today's Date __________

Home Address __________________________
City ____________ State ____________ Zip ____________
Home Phone ____________ Business Phone ____________ Cell Phone: ____________
Date of Birth ____________ Social Security # ____________
Employer __________________________
Nickname ____________

Party Responsible for Patient

☐Same as above
Name ____________ Address ____________
City ____________ State ____________ Zip ____________
Home Phone ____________ Business Phone ____________
Date of Birth ____________ Sex: ☐Male ☐Female
Social Security # ____________ Employer ____________

Occupation ____________ Referred By ____________

Your 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

Dr. Wi... L. Ratcliff, O.D.
Dr. Chris A. Ratcliff, O.D.
919 Fifth Avenue, Suite 100
Huntington, WV 25701
(304) 523-4819

Welcome to Our Office

Last Name ______________________ First Name ______________ MI ______

Date of last eye exam ____________ Dilated? ____________ Today's date ________

Medical Information

What is your general health? ______________________________

Do you have problem with any of these systems? (*Please circle all that apply*)

				Eyes	Y/N
Gastrointestinal	Y/N	Neurological	Y/N	Mental	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Endocrine (glands)	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Blood/Lymph	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Allergic/immunologic	Y/N

Please explain ______________________________

Please answer all that apply:

Diabetes Y/N Type ____________________ Date of diagnosis __________

Allergies Y/N Allergic to what? ______________________________

Medication allergy Y/N Headaches Y/N

Other health problems ______________________________

Current medication(s) ______________________________

Have you had any operations? Y/N Kind ______________ When? __________

Do you use cigarettes/tobacco? ________ Alcohol? ________ Other substance(s) ________

Name of family doctor ____________________ Date of last visit __________

Family History

High blood pressure	Y/N	Relation ________	Macular degeneration	Y/N	Relation ________
Diabetes	Y/N	Relation ________	Retinal detachment	Y/N	Relation ________
Glaucoma	Y/N	Relation ________	Cataracts	Y/N	Relation ________
Other eye condition(s)	Y/N	What Kind? ______________________			Relation ________

Personal Eye Information

Have you had any eye operations? Y/N Type ____________________ Date ________

Have you had an eye injury? Y/N Kind ____________________ Date ________

Do you have glaucoma? Y/N Cataracts? Y/N Dry Eyes? Y/N Blurred Vision? Y/N

Other eye problems? Y/N What Kind ____________________

Do you wear glasses? Y/N Contact Lenses? Y/N Type ____________________

Additional Information ______________________________

Doctor's initials ______________