

GADDY EYE CLINIC PATIENT INFORMATION SHEET

Last Name: _____ Date: _____
First Name: _____ Martial Status: _____
Middle Int: _____ Employer: _____
Sex: _____ Work Phone: _____
Home Phone: _____
Soc. Sec. #: _____
Date of Birth: _____ Age _____

Street Address Apt.#

City State Zip

Insurance Information:

Insurance Company: _____
Policy Holder: _____
Policy #: _____

Insurance Company: _____
Policy Holder: _____
Policy#: _____

In Case Of Emergency: _____ Phone: _____

Spouse's Name: _____
Spouse's Employer: _____ Work Phone: _____

Signature on File

I authorize payment benefits to be made payable to Dr. Gene Gaddy. My authorization is hereby given to Dr. Gene Gaddy to submit any claims to my insurance carrier in my behalf. I understand that I am responsible for deductible amount and the percent that my insurance does not cover.

Policy Holder/Patient

Date