GADDY EYE CLINIC PATIENT INFORMATION SHEET

Last Name: _____ Marital Status: _____

First Name: _____ Employer: _____

Middle Initial: _____ Suffix: _____ Sex: _____ Email: _____

Phone: _____ Work Phone: _____

Soc. Sec. # _____ Race: _____ Language: _____

Date of Birth: _____ Age: _____ Ethnicity: (please circle) Hispanic / Non-Hispanic

Street Address: _____

City, State, Zip: _____

INSURANCE INFORMATION:

Primary Insurance: _____

Policy Holder's Name: _____

Policy Number: _____

Policy Holder's SSN#: _____ Policy Holder's DOB: _____

Policy Holder's Employer: _____

Secondary Insurance: _____

Policy Holder's Name: _____

Policy Number: _____

Policy Holder's SSN#: _____ Policy Holder's DOB: _____

Policy Holder's Employer: _____

In Case of Emergency: _____ 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**