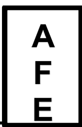


**Ada Family Eye Care**
**Dr. Chris Gurley**

# Patient Data Sheet

Today's Date:____________________

## PATIENT INFORMATION

| Patient's Last Name: | Patient's First Name: | Patient's Middle Name: |
|---|---|---|

Race / Ethnicity: ☐ American Indian ☐ Asian ☐ African American ☐ Hispanic ☐ Native Hawaiian ☐ White ☐ Other

Preferred Language: ☐English ☐Spanish ☐Other

| Date of Birth: | Sex: ☐Male ☐Female | SSN: | Marital Status: ☐Single ☐Married ☐Divorced ☐Widow |
|---|---|---|---|

| Street Address: | Mailing Address (if different): |
|---|---|

| City: | State: | Zip Code: | Home Phone: |
|---|---|---|---|
| Employer: | Work Phone: | Cell Phone: | Email: |

## ***FOR MINOR PATIENTS ONLY***

| Father's Name: | Cell Phone: | Alternate Phone: |
|---|---|---|

| Father's Employer: | Street, City, State, Zip: |
|---|---|

| Mother's Name: | Cell Phone: | Alternate Phone: |
|---|---|---|

| Mother's Employer: | Street, City, State, Zip: |
|---|---|

## CONTACT INFORMATION

| Emergency Contact: | Phone Number: | Relationship: |
|---|---|---|
| Address (If Different): | City (If Different): | State (If Different): |

## INSURANCE INFORMATION

**Vision Insurance:**

| Insurance Company: | Relationship to Insured ☐Self ☐ Spouse ☐Child ☐Other |
|---|---|

| Policy Holder: | Policy Identification Number: | SSN: |
|---|---|---|
| Group Number: | Holder Date of Birth: | Gender: ☐Male ☐Female |

**Primary Medical Insurance:**

| Insurance Company: | Relationship to Insured ☐Self ☐ Spouse ☐Child ☐Other |
|---|---|

| Policy Holder: | Policy Identification Number: | SSN: |
|---|---|---|
| Group Number: | Holder Date of Birth: | Gender: ☐Male ☐Female |

**Other Insurance:**

| Insurance Company: | Relationship to Insured ☐Self ☐ Spouse ☐Child ☐Other |
|---|---|

| Policy Holder: | Policy Identification Number: | SSN: |
|---|---|---|
| Group Number: | Holder Date of Birth: | Gender: ☐Male ☐Female |

I hereby authorize assignment of benefits to be paid directly to the doctor. This will remain in effect until revoked by me in writing. The Patient/guardian is responsible for all fees regardless of insurance coverage. Payment for services is expected at time of appointment, unless other arrangements have been made. I understand that I am responsible for payment in full for all coinsurance, deductibles, as well as any doctor's services which are determined to be non-covered. I authorize my physician to release any medical information necessary to process my bill. Further, I have read the HIPPA privacy notice given to me at the time of my appointment. I hereby authorize that all insurances provided above are complete and accurate and I understand that any insurance provided after the date of service cannot be filed.

| *Signature:* | Date: |
|---|---|