

Please fill out applicable fields of this "fillable" form. Print, date, sign, and bring it with you to the office.

Laser Eye Institute
Daniel S. Haddad, M.D.

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PATIENT INFORMATION SHEET

Last Name: _____
First Name: _____ MI: _____
Address: _____
City: _____
State: _____ Zip: _____
Home Phone: (____) _____ - _____
Cell Phone: (____) _____ - _____
2nd Phone: (____) _____ - _____
Social Security #: _____ - _____ - _____
Date of Birth: ____/____/____
Gender: Male Female Age: _____
Marital Status: Single Married Divorced Widowed

Occupation: _____
Employer: _____
Address: _____
City: _____
State: _____ Zip: _____
Work Phone: (____) _____ - _____
How did you hear about us? _____
Primary Care Dr: _____
City: _____ Phone: (____) _____ - _____
Emergency Contact: _____
Relationship: _____
Contact Phone: (____) _____ - _____

RESPONSIBLE PARTY IF OTHER THAN THE PATIENT

Name: _____
Relationship to Patient: _____
Address: _____
City: _____
State: _____ Zip: _____
Home Phone: (____) _____ - _____
2nd Phone: (____) _____ - _____

Social Security # _____ - _____ - _____
Employer: _____
Address: _____
City: _____
State: _____ Zip: _____
Work Phone: (____) _____ - _____
Date of Birth: ____/____/____

INSURANCE INFORMATION

PRIMARY INSURANCE

SECONDARY INSURANCE

PRESENT CARD AT FRONT DESK

Please do not fill out for employee use only

Contract active date: _____
Deductible: _____ Co-pay: _____
Vision coverage: Y or N Every: _____
Misc vision info: _____
Insurance verified by: _____ Date: _____

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Please do not fill out for employee use only

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Deductible: _____ Co-pay: _____
Vision coverage: Y or N Every: _____
Misc vision info: _____
Insurance verified by: _____ Date: _____

Release of Information:

I hereby authorize the attending physician to release my information acquired in the course of examination or treatment and allow a photocopy of my signature to be used.

Claim Payment Authorization:

The subscriber hereby authorizes his/her insurance company(s), at its option to issue indemnity checks to the provider rendering services.

Patient Responsibility: understand that I am responsible for any amounts that are not covered by my insurance. I also understand that I am responsible for securing any referral(s) needed by my insurance company for this, or any visit.

The initial refractive consultation is free of charge. Any medical information or records obtained from the consultation is used solely for the purpose of determining whether the patient the patient is a candidate for the procedure. This is not a routine check-up.

Date: ____/____/____

Signature of Patient: _____