Gooding Eye Care

317 Main. St.
Gooding, ID 83330

Demographics

Patient Information

First Name		Last			Middle
Mailing Address			SSN		
City	State	Zip	Cell		
Date of Birth		Age	Email		
Gender M F	Single Married		Other		
Responsible Party			Spouse's Name		
Emergency Contact		Relationship		Phone	

Preferred Payment Method Cash Check Debit/Credit Card

If Minor	Father	Phone
	Mother	Phone

If you have insurance, please present your insurance card to make a copy for our records.

Vision Insurance	Subscriber DOB
Medical Insurance	Subscriber DOB

For Workman's Compensation Claims	
Employer	Occupation
Employer's address & phone	

Please Read and Sign Below

I request that payment of authorized insurance benefits be made for me or on my behalf to Gooding Eye Care for any services furnished me by that provider. I hereby authorize Goodng Eye Care to furnish the insured's insurance company all information they request. I understand I am financially responsible to Gooding Eye Care for charges not covered by this assignment. I further authorize Gooding Eye Care to make photocopies of this authorization and assignment, in order for them to attach a copy to any insurance form and be able to retain the original copy in the doctor's files, and authorize the insurance company to accept the photocopy. I release Gooding Eye Care from all legal responsibility that may arise from this authorization. This authorization shall continue and be in force and effect until revoked in writing by me.

Patient/Guardian Signature	Date