Richard L. Powell, O.D., F.A.A.O.
Stephen P. Gildersleeve, O.D.
Suite A, 3200 “O” Street, Lincoln, NE 68510, (402) 475-9113
Thank you for selecting our services

Date _____

Patient Information

Check Appropriate Box Minor Single Married Divorced Widowed Separated

Name: _____ DOB: _____/_____/_____ Circle: M / F

Soc Sec #: _____/_____/_____ Banking Institution _____

Home Phone _____ Cell Phone _____ Email _____

Address _____ City _____ St _____ Zip _____

Patient’s/Parent’s Employer _____ Work Ph _____

Employer Address _____ City _____ St _____ Zip _____

Spouse, Parent or Other: _____ DOB: _____/_____/_____

Soc Sec #: _____/_____/_____ Banking Institution _____

Home Phone _____ Cell Phone _____

Address _____ City _____ St _____ Zip _____

Employer _____ Work Phone _____

Employer Address _____ City _____ St _____ Zip _____

If Patient is a Student, Name of School/College _____

City _____ State _____

Person to Contact in Case of Emergency _____

Phone _____ Address _____

Non Family Member _____

Phone _____ Address _____

Who is responsible for the patient’s medical care? _____

Date of last exam and where? _____

Whom May We Thank for Referring You? _____

~ TURN PAGE OVER ~

Insurance Information

Name of Insured _____ Relationship to Patient _____

DOB _____/_____/_____ Soc Sec # _____/_____/_____ Date Employed _____

Name of Employer _____ Work Phone _____

Employer Address _____ City _____ St _____ Zip _____

Insurance Company _____ Group # _____ Union/Local _____

Ins. Co Address _____ City _____ St _____ Zip _____

Insurance Company Phone # _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No If yes, Complete the following:

Name of Insured _____ Relationship to Patient _____

DOB _____/_____/_____ Soc Sec # _____/_____/_____ Date Employed _____

Name of Employer _____ Work Phone _____

Employer Address _____ City _____ St _____ Zip _____

Insurance Company _____ Group # _____ Union/Local _____

Ins. Co Address _____ City _____ St _____ Zip _____

Insurance Company Phone # _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the physician to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the physicians' office, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I understand I am responsible for all co-pays, deductibles, co-insurance and balances.

X_____ Date _____

Signature of Patient (or Parent if minor)

This form needs to be filled out completely in order for our services to be provided.