**GRIFFIN EYE CLINIC & SURGEONS**
**646 SOUTH 8TH ST.**
**GRIFFIN, GA 30224**
**770-228-3836**
**770-412-1733 Fax**

# INSURANCE INFORMATION

**NAME OF PATIENT BEING SEEN** _____

**PRIMARY INSURANCE PLAN**
Insurance Company Name_____Telephone_____
Address to Mail Claim_____
City _____State_____Zip_____

Name of Insured_____
Insured's Social Security Number_____
Relationship to Insured_____
Insured's Date of Birth_____
Policy #_____HMO____PPO____
Effective Date of Coverage_____

**SECONDARY INSURANCE PLAN**
Insurance Company Name_____Telephone_____
Address to Mail Claim_____
City _____State_____Zip_____

Name of Insured_____
Insured's Social Security Number_____
Insured's Date of Birth_____
Relationship to Insured_____
Policy #_____HMO_____PPO_____
Effective Date of Coverage_____

***PATIENTS ARE REQUIRED TO HAVE THEIR INSURANCE CARDS AT THE TIME OF SERVICE.*** If you do not have your insurance card to be presented to the receptionist, we will ask you to pay your visit in full at the time of service or you may reschedule your visit to a time when you will have your card with you. In case of emergencies, other arrangements can be made.