

PATIENT INFORMATION

Today's Date: _____

Name: _____ Age: ____ DOB: _____ SSN: _____

Title: (DR / MRS / MR / MS) Gender: M / F Race: _____ Ethnicity: _____ Preferred Language: _____

Address: _____ City: _____ St: _____ Zip: _____

Mailing Address: _____

Home Phone: _____ Cell: _____ Email: _____

*Preferred method of contact? Home Phone/Cell Phone/Text/ Email Work Phone: _____

Employer: _____ Occupation: _____

Marital Status: S M D W Spouse's Name: _____ DOB: _____

Spouse's SSN: _____ Spouse's Employer: _____

FOR CHILDREN UNDER 18 ONLY: School: _____ Grade: _____

Mother's Name: _____ Employer: _____ SSN: _____

DOB: _____ Address: _____

Father's Name: _____ Employer: _____ SSN: _____

DOB: _____ Address: _____

BILLING INFORMATION & EMERGENCY CONTACT

Is the patient responsible for the bill? YES NO If no, Guarantor name and address:

EMERGENCY CONTACT (not in the same household) Name: _____

Address: _____ Phone: _____ Relationship: _____

INSURANCE, EXTENDED SIGNATURE, AUTHORIZATIONS

Type of Insurance: _____ (Please provide card for copying.)

I consent to treatment necessary for care. I authorize the release of information to other health care providers and to insurance carriers for purposes related to treatment and/or reimbursement. I understand and accept responsibility for all fees not covered under insurance. I understand payment is due on the day of service.

I request that payment of authorized Medicare, Medicaid, or other insurance benefits be made on my behalf to West Georgia Vision Center for any service furnished to me by a provider of the group. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, or any other insurance, any information needed to determine these benefits payable for related services. I also request that the payment of Medigap benefits or other secondary insurance be made on my behalf to West Georgia Vision Center.

I HAVE READ THE ABOVE POLICES AND AGREE AS INDICATED BY MY SIGNATURE:

→ _____ Date _____
SIGNATURE OF ADULT (18 or older)

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM: I acknowledge that a copy of West Georgia Vision Center's Notice of Privacy Practices has been made available to me.

→ _____ Date _____

****Please sign in 2 areas!****