EYE ASSOCIATES OF SOUTH GA, LLC

Patient Information

Patient's Last Name	First	Middle	☐ Male ☐ Female

Age	Date of Birth	Mailing Address	Street Address

City	State	Zip Code	Social Security Number

Home Phone Number	Business Phone Number	Cell Number	Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Employer's Name	Employer's Address

Person to notify in case of an emergency (Phone number)

Patient's E-mail Address	Referred by

Were you injured on the job? ☐ Yes ☐ No	Are charges covered by Workman's Comp? ☐ Yes ☐ No Name and phone number of person to contact for Workman's Comp claim

Person Responsible for Financial Charges

Last Name	First	Middle	Social Security Number	Relationship to Patient	
Address			City	State	Zip Code

Home Phone Number	Business Phone Number	Place of Employment

Method of Payment: ☐ Cash/Check ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

INSURANCE - Please present your card to the receptionist

Name of Primary Insurance Company			Address	
Policy or Certificate No.	Group No.	Effective Date	Policyholder's Name / Date of Birth	Relationship to Policyholder

Name of Secondary Insurance Company		Address		
Policy or Certificate No.	Group No.	Effective Date	Policyholder's Name / Date of Birth	Relationship to Policyholder

How did you find out about us?

☐ Friend / Relative	☐ Newspaper	☐ Radio	☐ Television
☐ Physician	☐ Billboard	☐ Yellow Pages	☐ Practice Sign

I consent to treatment necessary for the care of the above patient. I authorize release of medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records if necessary.

I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I understand a $10.00 service charge will be charged if payment is not rendered at the time of service. I agree to pay all attorney fees and collections costs in the event of default of payment of my charges.

I further authorize and request that insurance payments be made directly to Eye Associates of South GA, should they elect to receive payment. I understand that I am responsible for paying deductibles and/or co-payment on the day service is rendered. I understand that it is my responsibility to verify whether the physicians at Eye Associates will be covered by my plan or not. I understand that I am responsible for payment in full regardless of any insurance arbitrary determination of rates unless Eye Associates has a contractual agreement with that company to write off any disallowed amounts.

Signature of Patient/Guardian _____ Date _____

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