SOUTH GEORGIA EYE PARTNERS, PC

PATIENT INFORMATION

Legal First Name _____ Middle _____ Last _____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ (Circle) Male / Female (Circle) Single / Married / Widowed / Separated / Divorced

Date of Birth_____ Age:_____ SSN#:_____

Patient Employed By:_____ Wk Phone:_____

Are You Retired? Yes / No Date Retired:_____ (Month/Year) E-Mail Address:_____

Cell Phone: _____ How did you learn about our office?_____

Name of Doctor who referred you:_____ City:_____ Phone #:_____

Whom to notify in case of emergency?:__ _____ Home Phone:_____ Wk Phone:_____

SPOUSE INFORMATION

Name:_____ Employer:_____

Date of Birth:_____ Work Phone:_____

SS #:_____ Retired? Yes / No Date Retired:_____

MUST COMPLETE IF UNDER 18 OR USING GUARDIAN'S INSURANCE

Father

Name:_____

Date of Birth:_____

SS #:_____

Employer:_____

Work Phone:_____

Mother

Name:_____

Date of Birth:_____

SS #:_____

Employer:_____

Work Phone:_____

AUTHORIZATIONS

************PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST************

- I hereby authorize and request the medical treatment necessary for the care of the above named patient.
- I authorize SOUTH GEORGIA EYE PARTNERS, PC to use and disclose protected health information about above named patient to carry out treatment, payment and healthcare operations. I understand that this may include the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow the fax transmittal of my medical records, if necessary.
- I acknowledge full financial responsibility for services rendered by SOUTH GEORGIA EYE PARTNERS, PC. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
- I further authorize and request that insurance payments be made directly to SOUTH GEORGIA EYE PARTNERS, PC should they elect to receive such.
- I acknowledge that I have received a copy of our Notice of Privacy Practices. A copy is located in the lobby of the office.
- I understand my email address may be used solely to relay information regarding appointments, non-critical test results, or other general information.
- I certify that the information I have provided is true and accurate and that I understand and agree to all the patient responsibilities outlined above.

I have read and fully understand the above consent for treatment, release of protected health information, financial responsibility and insurance authorization.

_____ _____

Date Patient / Parent or Guardian Signature