

**EYE ASSOCIATES OF SOUTH GA, LLC**  
Patient Information

Patient's Last Name			First	Middle	<input type="checkbox"/> Male <input type="checkbox"/> Female
Age	Date of Birth	Street Address			
City		State	Zip Code	Social Security Number	
Home Phone Number		Business Phone Number	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are charges covered by Workman's Comp? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Cash/Check <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> 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	Relationship to Policyholder	
Name of Secondary Insurance Company			Address		
Policy or Certificate No.	Group No.	Effective Date	Policyholder's Name	Relationship to Policyholder	

**How did you find out about us?**

<input type="checkbox"/> Friend / Relative	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Radio	<input type="checkbox"/> Television
<input type="checkbox"/> Physician	<input type="checkbox"/> Billboard	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> 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 \_\_\_\_\_