PATIENT INFORMATION

Today's Date: _____

Patient Name: _____ Age: _____ DOB: _____

Title: □ Dr. □ Mr. □ Mrs. □ Ms. □Other: ___ **Sex:** □M □F **SSN:** _____

Address: _____ **City:** _____ **St:** ____ **Zip:** _____

Work Phone: _____ **Home Phone**: _____ **Cell**: _____

Employer: _____ Occupation: _____

Children Under 18

Mother's Name: _____Employer: _____
SSN: _____ DOB: _____
Address: _____

Father's Name: _____Employer: _____
SSN: _____ DOB: _____
Address: _____

Marital Status: □**S** □**M** □**D** □**W** Spouse's Name: _____DOB: _____
Spouse's SSN: _____ Spouse's Employer: _____

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, PAYMENT AUTHORIZATION

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

MEDICARE EXTENDED PATIENT SIGNATURE AUTHORIZATION; MEDIGAP: I request that payment of authorized Medicare benefits be made on my behalf to West Georgia Vision Center. I request any holder of medical information about me to West Georgia Vision Center and its agents any information necessary to determine these benefits or the benefits for related services. If I have Medicare supplemental insurance to which my Medicare carrier automatically "crosses over," I authorize benefits to be paid on my behalf for all services furnished to me.

CONSENT; MEDICAL RECORDS RELEASE; FINANCIAL RESPONSIBILITY: I consent to treatment necessary for care. I authorize the release of all medical records to other health care providers and to medical insurance companies for purposes related to treatment and/or reimbursement. I understand and accept responsibility for all fees not covered under insurance. I accept the fees charged as a lawful debt and promise to pay said fees including finance charges, the cost of collection, attorney fees, and court costs if necessary. Payments due when services are rendered.

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 _____