PATIENT INFORMATION

Today's Date: _____

Name: _____ **Age:** ___ **DOB:** _____ **SSN:** _____

Title: (DR/MISS/MR/MRS/MS) **SEX:** M / F **Race**: _____ **Ethnicity**: _____ **Pref. 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 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 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 accept the fees charged as a lawful debt and promise to pay said fees including finance charges, collection costs, attorney fees, and court costs if necessary. I understand payment is due on the day of service.

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!*****