

 **GEORGIA**  
**EYEPARTNERS**  
**NEW PATIENT INFORMATION**

PATIENT'S NAME (PLEASE PRINT) \_\_\_\_\_

HOME ADDRESS: (NO P.O. BOXES PLEASE)

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME NUMBER: \_\_\_\_\_ WORK NUMBER: \_\_\_\_\_ AGE: \_\_\_\_\_

E-MAIL: \_\_\_\_\_ CELL NUMBER: \_\_\_\_\_

S.S. #: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ SEX: M / F

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

NAME & TELEPHONE # OF NEAREST RELATIVE / FRIEND:

**\*PAYMENT IS DUE AT TIME SERVICES ARE RENDERED\***

PERSON RESPONSIBLE FOR PAYMENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

MEMBER NAME: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

MEMBER DATE OF BIRTH: \_\_\_\_\_ MEMBER SS #: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

MEMBER NAME: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

MEMBER DATE OF BIRTH: \_\_\_\_\_ MEMBER SS #: \_\_\_\_\_

REFERRED BY: DOCTOR? \_\_\_\_\_ REFERRING DR. PHONE NUMBER: \_\_\_\_\_

FRIEND? \_\_\_\_\_ RADIO? \_\_\_\_\_ OTHER? \_\_\_\_\_

**ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR INSURANCE OFFICE. SHOULD YOUR ACCOUNT BE PLACED IN COLLECTIONS DUE TO NON-PAYMENT, YOU WILL BE RESPONSIBLE FOR THE ORIGINAL OUTSTANDING CHARGES, AS WELL AS ANY COLLECTIONS FEES INCURRED.**

I authorize Georgia Eye Partners to release any information about me to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim / other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for payment for my treatment.

Signature \_\_\_\_\_ Date \_\_\_\_\_