GEORGIA EYE SPECIALISTS
MARIETTA
www.georgiaeye.com

Welcome to our practice.

May we ask how you heard about our office?

_____ Friend _____ Doctor _____ Insurance Booklet _____ Drive by
_____ Relative _____ Yellow Pages _____ Employer _____ Emergency
_____ Newspaper Article _____ Internet _____ Mailing

If referred by a friend, relative, or doctor, please complete the following:

Name _____ Address _____ City _____ State _____ Zip _____

PATIENT INFORMATION (Please print) email address _____

Patient's name _____ Sex M_____ F_____

Date of Birth _____ Age _____ Social Security _____

Marital Status (circle one) Single Married Widowed

Address: Street _____ Apt./Lot #_____

City _____ State _____ Zip Code _____

Home Phone _____ Cell /Work Phone _____

Patient's Employer _____ Occupation _____

Employer's Address _____ City _____

Spouse/Parent/Guardian _____ DOB _____ SS# _____

Spouse/Parent/Guardian Employer _____ Work Phone _____

Family Physician _____ Phone _____

NEAREST RELATIVE/EMERGENCY CONTACT

Name _____

Relationship _____

Address _____

Phone _____

PERSON RESPONSIBLE FOR BILL (if not patient)

Name _____

Address _____

Phone _____ Relationship _____

DOB _____ SS# _____

ATTENTION: **Please be aware that most medical insurances and Medicare do not cover routine eye exams (that is, glasses or contact lens check). If you believe your insurance does cover routine eye exams, please let the front desk know BEFORE you are called to the back so that we may verify your insurance.**

Insurance Authorization and Assignment: I hereby authorize release of medical information to my insurance company and assign to the physician(s) all payments for services rendered to me or my dependents. As is the case with most insurance agreements, the insurance contract is between the patient and the insurance company and not between the insurance and GES. *Payment is expected at the time of the visit, and I understand that I am responsible for any amount not covered by insurance. I understand that testing for glasses and contacts is usually not covered by medical insurance, and I am responsible for this charge. It is my responsibility to obtain a referral should my insurance require it. I must provide a current insurance card.* Thank you for your understanding with these insurance matters.

If your insurance has not paid within 30 days, the balance will become the patient's responsibility.

Date: _____ Signature: _____

PLEASE NOTE: We require payment at time of service. Please indicate how you wish to pay: Cash, Check, CC. There will be a $40.00 fee for all returned checks.