New Patient Information

Account Number	Incoming Complaint (What problems are you having with your eyes?)						
Date							
Patient Information							
Name (Last, First, MI)						Mr. Mrs. Ms. Dr. Other:	
Date of Birth	Age	Social Security Number				Race	
Mailing Address – Street		City, State		Zip		County	
Home Phone	Cell Phone		Email Address				
Referred by:			Preferred Pharmacy & Location				
Employer			Work Phone				
Marital Status			Spouse's Name				
Spouse's Date of Birth			Spouse's Cell Phone				
Spouse's Employer			Spouse's Work Phone				
Who should we contact in case of an emergency (nearest friend or relative)? Name: Relationship: Phone:							
Responsible Party Information ☐ **Same as patient**							
Name (Last, First, MI)						Mr. Mrs. Ms. Dr. Other:	
Date of Birth				Social Security Number			
Address – Street	City			State		Zip	
Home Phone	Cell Phone			Work Phone			
Is this examination for Contact Lenses?			Yes		No		
If injury, did you receive it at work?			Yes		No		
Date of accident?							
Describe how accident happened:							
Check Method of Payment ☐ Cash ☐ Check ☐ Credit Card ☐ Debit Card							

Insurance Information		
Primary Insurance	Policy Holder's Name	Policy Number
Secondary Insurance	Policy Holder's Name	Policy Number

Policy Holder Information			
Name (Last, First, MI)			Mr. Mrs. Ms. Dr. Other:
Date of Birth	Social Security Number		
Mailing Address – Street	City, State	Zip	County
Home Phone	Cell Phone	Work Phone	

Treatment Consent

I authorize this facility and professional staff it may designate to carry out procedures, administer treatment and perform care as indicated.

Insurance Authorization & Assignment
I hereby authorize Eye Center of Central Georgia and Medical Eye Associates to furnish information to insurance carriers concerning my illness and treatments. I hereby assign to the physicians all payments for medical services rendered to my dependents or me.

Medicare Authorization & Assignment
I request payment of authorized Medicare benefits be made on my behalf to Eye Center of Central Georgia and Medical Eye Associates for any service furnished me. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Service and its agents any information needed to determine these benefits payable for related services.

PATIENT OR GUARDIAN SIGNATURE　　　　DATE

Medical Record Release

I authorize the release of medical information via phone, fax, or mail to the primary physician and other physicians or facilities involved in the care of this patient.

Refractions
Refraction is the only non-covered service that is routinely a part of your eye exam. Refraction is NEVER covered by Medicare and rarely covered by private insurance. **Please understand that if you decline refraction, we will be unable to prescribe new glasses for you or prescribe any changes in your existing glasses.** We will also lose the ability to evaluate your best correctable vision in order to rule out decreased vision that may be caused by a medical condition.
Understanding that above, if you still wish to decline the Refraction, please inform the technician at the beginning of your exam.

Financial Responsibility/Payment Policy
YOU ARE ULTIMATELY RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. **ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.** IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH CURRENT INSURANCE INFORMATION AT CHECK-IN.

I HAVE READ, UNDERSTAND, AND ACCEPT THE ABOVE STATEMENTS.

PATIENT OR GUARDIAN SIGNATURE　　　　DATE