North Fulton Eye Center & Cumming Eye Clinic Patient Information

Referred by _____ Date of Service _____

Primary Care Physician/ Family doctor: _____

Patient Name._____
First Middle Last Suffix

Home Address_____

City_____State_____ Zip Code_____

Home Phone_____ Cell Phone_____

E-mail address_____ Marital Status Single Married Divorced Widowed

Social Security Number_____ Date of Birth_____ Age _____ Gender M F

Ethnicity _____ Asian _____ African American _____ Caucasian _____ Hispanic
_____ Native American _____ Not Hispanic _____ Other

Employer/Parent's Employer_____Occupation_____

Work Address_____Work Phone_____

City_____State_____Zip Code_____

Spouse name (Parent name if minor) _____Spouse/Parent Work Phone_____

Person to notify in case of emergency (other than spouse) _____

Phone number (s) _____Relationship_____

Primary Insurance Company

Policy Holder _____ Relationship _____

Date of Birth _____

ID#	Group #	Effective Date

Secondary Insurance Company

Policy Holder _____ Relationship _____

Date of Birth _____

ID#	Group #	Effective Date

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to North Fulton Eye Center to be applied to my account for services rendered.

I agree to be financially responsible for all payment of all services rendered on my behalf or my dependent in the event that insurance denies payment and or may pay less than the actual bill for services. I understand that delinquent accounts are subject to collection and I acknowledge responsibility. I also understand that if I cancel my appointment less than 24 hours in advance, or fail to appear for a scheduled appointment, I will incur a fee of no less than $30.00.

For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

_____ _____

Patient's signature today's date