

# North Fulton Eye Center & Cumming Eye Clinic

## Patient Information

Name			Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address			Birth Date	
City	State	Zip	Social Security No.	
Employer			<b>Marital Status :</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner	
Primary Care / Referring Physician:			<b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined to Specify	
Tell us How you Heard about our Practice			<b>Language:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Declined <input type="checkbox"/> Other _____	
<b>Race:</b> <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Declined to Specify				
<b>E-mail:</b> _____ <input type="checkbox"/> Personal <input type="checkbox"/> Business				

## Contact Information

Primary Telephone:	Secondary Telephone:	May we leave messages and/or Medical information on your voicemail? ___ YES    ___ NO	Permission to contact via e-mail    __Y __N Permission to contact via TEXT    __Y __N
Pharmacy (location-street & city)		Pharmacy Phone #	
<b>HIPAA/Emergency Contact?</b> Name _____ Relationship to Patient _____ Phone# _____			

Primary Insurance Information	Secondary Insurance Information
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Insurance Company		Insurance Company	
ID Number		ID Number	
Group Number		Group Number	
Name of Insured		Named of Insured	
Relationship to Patient		Relationship to Patient	
Insured's SS#	Insured's Date of Birth	Insured's SS#	Insured's Date of Birth

Responsible Party (IF OTHER THAN PATIENT)	GUARANTOR Must be fully COMPLETED
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Full Legal Name			Birth Date	Relationship to Patient
Address			Driver's License No.	Cell Phone:
City	State	Zip	Home Phone	Work Phone

I authorize North Fulton Eye Center/Cumming Eye Clinic to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practitioners  
 I authorize and request my insurance company to pay directly to the doctor, or doctor's group, insurance benefits otherwise payable to me.  
 I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. 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 services, I will incur a fee of no less than \$30.00.

**X** \_\_\_\_\_  
 Signature of patient or parent of minor Date

I acknowledge that I received and read the HIPAA privacy policy (available upon request) for this office.

**X** \_\_\_\_\_  
 Signature of patient or parent of minor Date