North Fulton Eye Center & Cumming Eye Clinic

Patient Information

Name			Date	☐Male ☐Female
Address			Birth Date	
City	State	Zip	Social Security No.	
Employer			Marital Status : ☐Single ☐Married ☐Divorced ☐Widowed ☐Domestic Partner	
Primary Care / Referring Physician:			Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to Specify	
Tell us How you Heard about our Practice ______________________________			Language: ☐English ☐Spanish ☐Declined ☐Other ____________	
Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Declined to Specify				
E-mail: ______________________________ ☐Personal ☐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 #	
HIPAA/Emergency Contact? Name______________________ Relationship to Patient______________ Phone#______________			

Primary Insurance Information		Secondary Insurance Information	
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

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 $50.00.

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 if minor **Date**