Allatoona Eye Institute - Eye M.D.s

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Welcome To Our Office

PATIENT INFORMATION

Date_____

PATIENT'S NAME (PLEASE PRINT)	S.S.#	MARITAL STATUS S M W D SEP	SEX M F	BIRTHDATE	AGE
MAILING ADDRESS & STREET ADDRESS IF P.O. BOX	CITY AND STATE	ZIP CODE		HOME PHONE #	
PRIMARY CARE PHYSICIAN	EMPLOYER	HOW LONG EMPLOYED		BUS. PHONE # EXT#	
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE	
DRUG ALLERGIES, IF ANY					
SPOUSE OR PARENT'S NAME	S.S. #	BIRTHDATE			
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED		BUS. PHONE #	
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE	
OTHER CONTACT IN CASE OF EMERGENCY	CITY AND STATE	ZIP CODE		HOME PHONE #	

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICES. IF HOSPITALIZATION IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION.

PRIMARY INSURANCE

Name of Policy Holder_____
Last Name First Name Initial

Relation to Patient_____ Birthdate_____ Soc. Sec. #_____

Address (If different from patient's_____ Phone_____

City_____ State_____ Zip _____

Insurance Company _____

Member ID #_____ Group #_____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name_____ Relation to Patient_____ Birthdate_____

Address (If different from patient's)_____ Phone_____

City_____ State_____ Zip_____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder_____ Policy/Medicare #_____

I request that payment of authorized Medicare/Other insurance company benefits be made either to me or on my behalf to_____ for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other insurance company claim.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/Other insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/Other insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other insurance company.

Signature_____ Date_____