



The Region's Multispecialty Eye Care Provider

## CONFIDENTIAL RECORD FORM

Name: \_\_\_\_\_  
LAST FIRST INITIAL

Companion: \_\_\_\_\_  
NAME RELATIONSHIP

Mailing Address: \_\_\_\_\_  
STREET CITY STATE ZIP

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ SSN: \_\_\_\_\_

Home Phone Number: \_\_\_-\_\_\_-\_\_\_ Work Phone: \_\_\_-\_\_\_-\_\_\_

Email Address: \_\_\_\_\_ Cell Phone: \_\_\_-\_\_\_-\_\_\_

Emergency Contact & Phone: \_\_\_\_\_

Family Physician Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

How did you hear about us: (Circle One)

Doctor Referral    Customer Referral    Friend/Family    Newspaper    Radio    TV

Yellow Page    Bill Board    Walk-in    Other: \_\_\_\_\_

I authorize West Georgia Eye Care Center and/or any physicians associated with this practice to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that all copayment(s) and/or deductibles and any amounts not covered or authorized by my insurance company are subject to payment at the time the services are rendered.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_