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: _____