PATIENT INFORMATION: (PLEASE PRINT)

NAME: _____ AGE: _____ M/F:_____

ADDRESS: _____ CITY, STATE, ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

PATIENT'S EMPLOYER: _____ POSITION: _____

BUSINESS ADDRESS: _____ CITY, STATE, ZIP: _____

SPOUSE/PARENT NAME: _____ SS#: _____

EMPLOYER: _____ WORK PHONE: _____

PRIMARY INSURANCE: _____ POLICY #: _____

SECONDARY INSURANCE: _____ POLICY #: _____

EMERGENCY CONTACT: _____ PHONE #: _____

Who is your medical doctor? _____ Allergies: _____

What medical problems do you have? HBP Diabetes Heart Disease Kidney Disease

Lupus Thyroid Disease HIV+/AIDS Hepatitis Stroke Other _____

List any surgeries you have had in your lifetime: _____

_____

What are your present eye complaints? _____

Do you wear glasses? Yes No How Long? _____ Prescribed where? _____

Do you wear contact lenses? Yes No How Long? _____ Prescribed where? _____

Have you ever had eye surgery? Yes No What kind? _____

Who performed your eye surgery? _____ When? _____

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

Patient's Signature: _____ Date: _____