North Georgia Eye Care

PATIENT INFORMATION	**(PLEASE PRINT)**

Today's Date:______________________

Patient's Name: Last____________________________First____________________________

Marital Status ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Single

Social Security Number____________________Driver License Number_________________

Date of Birth:________________________Home Telephone # (_____)__________________

Work Telephone # (_____)__________________Cell Phone # (_____)__________________

Home Address_______________________________City, State, Zip_____________________

Employment Status: ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired
☐ Self Employed ☐ Unemployed

Employer/School______________________Occupation/Grade_________________________

Spouse's Name: Last_____________________________First___________________________

Spouse's Employer:_________________________Spouse's Date of Birth:________________

RESPONSIBLE PARTY INFORMATION	**(IF OTHER THAN SELF)**

Responsible Party Name: Last_________________________First______________________

Social Security Number_____________________________Date of Birth__________________

Home Phone #____________________Work #__________________Cell #_______________

Home Address____

City__________________________State_______________________Zip___________________

Employment Status: ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired
☐ Self Employed ☐ Unemployed

Employer____Occupation_____________________

Patient Relationship to Responsible Party____

MEDICAL INSURANCE INFORMATION

Name of Medical Insurance Company____

Name of Primary Policy Holder____

Primary Policy Holder Social Security Number___________________DOB_____________

Relationship to Primary Policy Holder____

VISION INSURANCE INFORMATION

Name of Vision Insurance Company____

Name of Primary Policy Holder____

Primary Policy Holder Social Security Number___________________DOB_____________

Relationship to Primary Policy Holder____

PRIMARY CARE PHYSICIAN

Name of Primary Care Physician____

Primary Care Physician Address____

City___________________State___________________Zip_______________

Primary Care Physician Phone Number____

HOW DID YOU HEAR ABOUT OUR OFFICE? (Circle one below)

Yellow Pages   Your Ins. Co.   Referral   Passed By   Website

(PLEASE COMPLETE REVERSE SIDE OF THIS FORM)

ARE YOU CURRENTLY BEING TREATED FOR ANY OF THE FOLLOWING?

	Y	N		Y	N
High Blood Pressure	☐	☐	Cataracts	☐	☐
Heart Problems	☐	☐	Flashes of Light	☐	☐
Cancer____________________	☐	☐	Floaters	☐	☐
Thyroid Disease	☐	☐	Temp. Loss of Vision	☐	☐
Stroke	☐	☐	Eye Injury___________	☐	☐
Glaucoma	☐	☐	Eye Surgery__________	☐	☐
Arthritis	☐	☐	Double Vision	☐	☐
HIV	☐	☐	Eye Turn/Lazy Eye	☐	☐
Hepatitis	☐	☐	Allergies (seasonal)	☐	☐
Diabetes	☐	☐	Other:______________	☐	☐
Pregnant	☐	☐			

FAMILY HISTORY: (specify relation on line)

Glaucoma ___________________	☐	☐
Diabetes ___________________	☐	☐
Blindness ___________________	☐	☐

Medications you are Currently Taking:____

____

Known Drug Allergies:____

Reason for Today's Visit (Chief complaint)

☐ Medical/Visual Problems (if yes, please specify)_________________________________

☐ Routine Eye Exam ☐ First Eye Exam ☐ Broken/Lost Eyewear ☐ Interested in New Eyewear

☐ Headaches ☐ Dry Eyes ☐ Red, Itchy, Watery Eyes

I Currently Wear:

☐ Eyeglasses ☐ Contacts ☐ CL's and Eyeglasses ☐ Sunglasses

If contacts, what brand do you wear?____

What power are your contacts? Right:______________________Left:________________________

Pupil Dilation

The use of eye drops to dilate your pupils allows a better view inside the eyes as part of the ocular health testing. Common side effects, lasting 3-5 hours, are increased light sensitivity, glare and reduced near focusing ability. Distance vision is not significantly affected in most people.

_____Yes, I give my permission to have my pupils dilated

_____No, I do not wish to have my pupils dilated

_____I would like to discuss dilation with the doctor

____

I agree that the information supplied on this form is accurate to the best of my knowledge. I hereby authorize North Georgia Eye Care to release information to my insurance company for services rendered. I authorize benefits to be paid directly to North Georgia Eye Care. I understand that verification of my insurance benefits via phone/internet is not a guarantee of payment. I understand that I am responsible for any unpaid balances not paid by my insurance. Any outstanding balances over 90 days past due will be turned over to the Collection Services of Athens for further collection procedures.

X____

Signature of Parent/Guardian/Responsible Party Date

North Georgia Eye Care Cancellation / No-Show Policy

Here at North Georgia Eye Care we strive to provide the highest quality service possible to all of our patients. We are always happy to try to schedule appointments to accommodate your busy schedule. However, if you are unable to keep an appointment, we ask that you give us a 24 hour notice. Making your appointment as scheduled is very important, not just for us, but for you as well. Appointment times are in demand and a missed appointment is not only lost revenue for us, but an appointment time that someone else could have used.

If negative circumstances require you to cancel a scheduled appointment, we request that you do so at least 24 hours in advance. If you cancel your appointment without a 24 hour notice or if you fail to show up for your appointment time, a $25 charge will be applied to you account. North Georgia Eye Care also reserves the right to cease rescheduling appointments due to habitual no-shows or cancellations.

While we are not fond of the negative connotation of any cancellation policy, we believe such a policy allows us to better schedule our patient's appointments at times that are convenient for them and is fair for everyone.

Thank you for your consideration and understanding on this matter and we look forward to your appointment time with us.

I have read the above and understand the cancellation / no-show policy of North Georgia Eye Care.

____ __________________

Patient/Guardian Signature **Date**