Please Provi	de Photo ID a	and Insurance Cards For Copying			
Primary Insurance:					
Policyholder's Name:		Relationship to Patient:			
Policyholder's Date of Birth:					
Secondary Insurance:					
Policyholder's Name:		Relationship to Patient:			
Policyholder's Date of Birth:					
Worker's Compensation:					
	Injury Date	Contact person Phone #			
Αι	ıthorization A	ssignment of Benefits			
or medical information about nor other insurance any information assigned cases, the provider a responsible for the Medicare dicovered services. I also request that the payment me or on my behalf to Georgia a physician of the group. I autinsurer any information needed responsible for any deductible, This assignment shall remain in considered as valid as the originals.	me to release to the Contion needed to deterring the cheductible, co-insurance medical	ded to me by a physician of the group. I authorize any holder denters For Medicare & Medicaid Services (CMS) and its agents mine these benefits payable for related services. In Medicare harge determination of the Medicare contractor, and I am the or the 20% Medicare does not pay, and for any non-ce or the 20% Medicare does not pay, and for any non-			
	Refraci	tion Services			
examination, but is considered	termining the need for a non-covered serv he patient. Our office	r glasses or contact lenses. It is an essential part of an eye vice by Medicare and many insurance companies; thus it fee for refraction is \$35.00 and this fee is collected at the			
responsibility for the cost of the co-pay.	e refraction and under	hat the refraction is a non-covered service. I accept financial rstand it is separate from and not included in the insurance			
		Date:			
Privacy Notice					
I acknowledge that a copy of the	ne Privacy Notice of G	Georgia Vision Institute, P.C. is available upon request.			
Signature:		Date:			

GEORGIA VISION INSTITUTE PATIENT INFORMATION SHEET

Name:			Sex:	Age:		
Last	First MI					
Date of Birth:	Soc. Soc. Soc. Soc. Soc. Soc. Soc. Soc.		Email Addres	6 :		
Home Phone:		Work		Cell Phone:		
Home Addre	ss:					
Preferred Contact:	Home Phone	Cell Phone	Work Phone	Other		
Preferred Language:	English Spa	nish Other				
Race:	White Asia	an Black/	African American	_ Prefer Not To Answer		
	American Indian/A	Alaskan Native	Native Hawaiian,	Pacific Islander		
Ethnicity:	Hispanic/Latino	Not Hispanio	:/Latino Origin	Prefer Not To Answer		
Patient's Employer:			Occupation:			
Marital Statu	is:					
Emergency C	a Minor, List Parent/G	iuardian Name:				
	le Your Home: Nan	ne	Relationship	Phone		
Referring Doctor:						
Primary Care Doctor:						
machine/voi	Georgia Vision Institut cemail pertaining to n ance information and	ny care. This m	ay include appoints	n an answering ment information,		
following ind	eorgia Vision Institut lividuals. This may ind ilts and/or discussion	clude appointm	ent information, bil	pertaining to my care wit ling/insurance informati	th the on,	
	Name	The state of		Relationship	,	
	Name			Relationship		
I do no care with any		Georgia Vision I	institute to share in	formation pertaining to	my	
Signature:			Date:			