AUGUSTA EYE M.D., PC

Gavin W. Davis, MD   *Stuart D. Marks, MD*

PATIENT REGISTRATION

DATE:_________________________

NAME:____

ADDRESS:____

CITY:_____________________STATE:_____________________ZIP:________________

PHONE:__________________________ ALTERN. PHONE:________________________

BIRTHDATE:__________________SEX:____________SOC SEC NO:_______________

GUARANTOR NAME:__________________________________ DOB:_______________

GUARANTOR SOC SEC NO:_________________________________

PRIMARY CARE DOCTOR: _____________________________________

PRIMARY DOCTOR PHONE:__________________________

OUR OFFICE REQUIRES A SOCIAL SECURITY NUMBER AND PHOTO ID FOR EACH PERSON. IF WE DO NOT HAVE A SOCIAL AND ID WE WILL NOT FILE INSURANCE AND PAYMENT IN FULL FOR YOUR EXAM IS DUE AT CHECK IN.

AS A COURTESY, OUR OFFICE WILL BE HAPPY TO FILE YOUR INSURANCE FOR YOU. YOU MUST PRESENT YOUR INSURANCE CARD AT CHECK- IN IN ORDER FOR US TO FILE FOR YOUR VISIT. IF YOU HAVE VISION SERVICE PLAN (VSP), WE NEED TO KNOW BEFORE YOUR EXAM SO WE CAN AUTHORIZE YOUR VISIT.

SOME PATIENTS HAVE "ROUTINE" BENEFITS WITH THEIR INSURANCE POLICY. IF YOU WANT US TO FILE YOUR VISIT AS A "ROUTINE" EXAM, YOU MUST LET US KNOW AT CHECK-IN. IT IS THE RESPONSIBILITY OF THE PATIENT TO KNOW YOUR BENEFITS BEFORE YOU ARE SEEN.

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NEEDED TO PROCESS MY INSURANCE CLAIM TO MY INSURANCE COMPANY AND REQUEST BENEFITS BE PAID TO THE PHYSICIAN ON ASSIGNMENT.

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE PAYMENT OF MEDICAL SERVICES, AND, IN THE EVENT MY INSURANCE REFUSES PAYMENT OR DOES NOT COVER MY SERVICES, I WILL BE RESPONSIBLE FOR PAYMENT.

SIGNATURE:_________________________________DATE:_______________________