Augusta Eye MD

PLEASE COMPLETE ENTIRE FORM

Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Nickname (or preferred name):	Primary Language:	Social Security No.: - -	Race:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street Address:	City:	State:	ZIP Code:
Mailing address (if different from above):	City:	State:	ZIP Code:

Home phone no.:	Work phone no.:	Cell phone no.:	Email address:
( )	( )	( )	

Occupation:	Employer:	Employer phone no.: ( )

Employer Address:	City:	State:	ZIP Code:

Parent/Guardian or Responsible Party (RP):	(RP) Social Security No.: - -	Parent/Guardian or Responsible Party's Address:	(RP) Phone no.: ( )

Parent/Guardian or Responsible Party's Employer:	(RP) Employer address:	Employer phone no.: ( )

Have you ever been a patient here before? ❑ Yes ❑ No	If so, when?	Family seen here:
Primary Care Doctor:	Referring Doctor:	
Preferred Pharmacy:	Location	

INSURANCE INFORMATION

(Please present your Insurance card(s) at the Check In desk.)

Patient's relationship to Policyholder:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of primary insurance:	Policyholder's name:	Policyholder's DOB: \ \	Is the Policyholder currently employed? ❑ Yes ❑ No
Name of secondary insurance (if applicable):	Policyholder's name:	Policyholder's DOB: \ \	Is the Policyholder currently employed? ❑ Yes ❑ No

Please list any additional insurance policies or pertinent insurance information:

IN CASE OF EMERGENCY

Contact name:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **AEMD** or insurance company to release any information required to process my claims.

Patient/Guardian signature ***Date***