**Southeast Retina Center PC - Augusta (706) 650-0061**

**Patient Information as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (enter today’s date)**

**(Please Print Legibly & Fill In or Correct All Fields)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient’s Name** |  |  |  |
|  | Last | First | Middle |
| Address |  |  |  |  |
|  | Street & Apt # | City | State | Zip |
| Home Phone |  | Cell Phone |  | Other Phone  |  |
| Any restrictions for contacting you? |  No  Yes | E-mail |  |
| Contact Restrictions: |  | Drivers License # (include State) |  |
| Age |  | Birthdate |  / / | SS# |  - - | Sex |  Female  Male |
| Marital Status |  Single |  Married to: |  |  Other: |  |
| **Patient’s Employer** |  | Occupation |  |
| Work Phone |  | Ext: |  | Is it okay to call you at work? |  Yes  No |
| Address |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  | Street & Suite # | City | State | Zip |
| **Hipaa Contact name**  |  | Relationship to Patient |  |
| Home Phone |  | Work Phone |  | Other Phone |  |
| Address |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  | Street & Apt # | City | State | Zip |
| **Emergency Contact**(Not in your household) |  | Relationship to Patient |  |
| Home Phone |  | Work Phone |  | Other Phone |  |
| Address |  |  |  |  |  |  |
|  | Street & Apt # | City | State | Zip |
|  |  |  |  |  |
|  |  |  |  |  |
|  **PCP Name**  |  | Phone  |  |
| **Pharmacy Name**  |  |  |  | Phone |  |
| Address |  |  |  |  |  |  |
|  | Street & Apt # | City | State | Zip |
|  |  |  |  |  |
|  |  |  |  |  |
| **Primary Health Insurance Company** |  |
| Policy # |  | Group # |  | Ins. Phone |  |
| Referral Required? |  No  Yes | Copay? |  No  Yes, | $ |  |
| **Insured**: Name |  | DOB |  | Employer |  |
| **Secondary Health Insurance Company** |  |
| Policy # |  | Group # |  | Ins. Phone |  |
| Referral Required? |  No  Yes | Copay? |  No  Yes, | $ |  |
| **Insured**: Name |  | DOB |  | Employer |  |
| I understand that office visit charges are payable on the day service is rendered. I authorize Southeast Retina Center to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Southeast Retina Center and myself. |
| **Signature** |  | **Date** |  |