

**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)**

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| **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 | | |  | | | | | | | | | |  | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | |  |
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|  | | | Street & Suite # | | | | | | | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | | | | | State | | | | Zip |
| **Hipaa Contact name** | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | Relationship to Patient | | | | | | | | | |  | | | | | | | | | |
| Home Phone | | | | | |  | | | | | | | | Work Phone | | | | | | | |  | | | | | | | | | Other Phone | | | | | | | | |  | | | | | | | | |
| Address | | |  | | | | | | | | | |  | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | |  |
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|  | | | 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 |
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| **PCP Name** | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | Phone | | | | | | | | | |  | | | | | | | | | |
| **Pharmacy Name** | | | | | |  | | | | | | | |  | | | | | | | |  | | | | | | | | | Phone | | | | | | | | |  | | | | | | | | |
| Address | | |  | | | | | | | | | |  | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | |  |
|  | | | Street & Apt # | | | | | | | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | | | | | State | | | | Zip |
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| **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** | | | | | |  | | | | | | | |