

Registration :

Georgia Vision Center, LLC

Date	Account ID	Chart ID	Other ID	Internal Use
------	------------	----------	----------	--------------

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #
Address			Home:	How did you hear of us?			
Address 2			Work:				
			Cell:				
			Email:				
City	State	Zip Code	Employer Name & Address			Occupation	
Emergency Contact		Phone	Pharmacy			Pharmacy Phone	

Pref Language: _____ **Race:** _____ **Ethnicity:** _____ **County:** _____

Provider _____ **Family Physician** _____ **Referring Physician** _____

Medical Insurance	Name & Address	Policyholder	Relationship	Copay	Policy ID	Group ID
1						
2						
3						

Guarantor (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
Address			Home:	Work:	Email:	
City	State	Zip Code	Employer Name & Address			Occupation
2 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
Address			Home:	Work:	Email:	
City	State	Zip Code	Employer Name & Address			Occupation

HIPAA Approved Contacts

1 Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship
Address		City	State	Zip Code	Home:	Cell:
					Work:	
2 Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship
Address		City	State	Zip Code	Home:	Cell:
					Work:	

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Georgia Vision Center, LLC , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date	Georgia Vision Center, LLC	Phone: 706-896-3303
X		344 Main Street South	Email:
		Hiawassee, GA 30546	

Please attach all pertinent insurance ID cards for photocopying.