Georgia Ophthalmologists ASC

4159 Mill St NE
Covington, GA 30014-2565
USA
(770) 786-1234

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS	ETHNICITY

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP	RACE

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE
	☐ Full-Time ☐ Part-Time					

SEXUAL ORIENTATION	PREFERRED PRONOUN	GENDER IDENTITY	

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE
	☐ Full-time ☐ Part-time				

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#
ADDRESS OF INSURANCE COMPANY			COPAY AMT $
CITY, STATE ZIP	PHONE		DEDUCTIBLE $
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SIGNATURE OF PATIENT/GUARDIAN

DATE

Georgia Ophthalmologists

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ **Patient Date of Birth:** _____

I hereby acknowledge that I have received a copy of Georgia Ophthalmologists, LLC's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____
Signature of Patient or Legal Representative **Date**

_____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)
- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

_____ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

_____

_____

_____

_____

_____

- ☐ Other (Specify)

_____

_____

_____

_____

_____

Covington Office
4159 Mill Street NE
Covington, GA 30014
Tel: 770-786-1234
Fax:: 770-385-0813

Jackson Office
860 W. 3rd Street
Jackson, GA 30233
Tel: 770-775-1234
Fax: 770-775-4030

Athens Office
1747 Langford Dr.
Bogart, GA 30677
Tel: 706-549-0005
Fax: 770-385-0813

Ambulatory Surgery Center
4159 Mill Street NE
Covington, GA 30014
Tel: 770-786-1234
Fax: 770-728-1570

Acknowledgment of Financial Responsibility

Here at the Georgia Ophthalmologist, we want to make sure you have the necessary information to be reimbursed for all covered services. Please understand your insurance only covers services when their rules are met.

- ***Insurance coverage***: It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and authorization requirements as well as vision services. This information is furnished by your insurance carrier. We make copies of you insurance cards assuming the coverage is active at the time of your visit. If your coverage is not in effect at the time of services, you will be responsible for payment.

- ***Insurance Changes***: If you have any changes in your insurance coverage, please notify us. Failure to do so may result in a claim denial and you will be billed.

- ***Co-payments, Co-insurance, and deductibles:*** Co-insurance and co-payments are the patient's/policy holder's responsibility. Co-payments are due at the time of service. Deductibles are the responsibility of the patient/policy holder.

- ***Refractions***: Insurance companies do not pay for refractions unless you are entitled to a routine eye exam or have a separate vision plan. In these instances, refraction fees are due at the time of service.

- ***Referrals*:** If your plan requires a referral, it is your responsibility to obtain it from your primary doctor prior to your visit. If you wish to be seen without a referral you must sign and comply with our missing referral form.

- ***Insurance Payments***: If by error, an insurance check is sent to you, you should immediately be forwarded to our billing office along with a copy of the explanation of benefits (EOB).

- ***Self Pay Patients***: Self pay patients must pay in full for the examination before any services can be rendered. If after your initial visit further testing is required, pricing will be discussed prior to any procedures.

- ***Cancellation policy:*** If you need to cancel your appointment we ask that you cancel at least 24 hours prior to the scheduled time. You must notify our office within 24 hours of your appointment or you will be charged $25.00. This policy also applies to not showing up for your scheduled appointment.

Name of Patient (PRINT) Signature Date

Signature of Patient Representative Relationship to Patient Date

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Georgia Ophthalmologists

Medical History Questionnaire

Patient Name _____ D.O.B _____ Date _____

Pharmacy Name _____ Location _____

Please list any medications you are currently taking (include prescribed and over the counter medications)

_____

_____

Do you have any allergies to any medications? … YES NO *If yes, please list:* _____
Do you have any food allergies? …….. YES NO *If yes, please list:* _____
Do you have an allergy to LATEX products? …… YES NO *If yes, please list:* _____

List any surgeries you have had in the past: _____

_____

Please check all that apply:

□ Poor Vision	□ Macular Degeneration	□ Floaters	□ Poor Night Vision
□ Diabetes	□ Tired Eyes	□ Other Eye Surgery	□ Flashes of Light
□ Glaucoma	□ Family History Glaucoma	□ Color Vision Problems	□ Eye Strain
□ Retinal Problems	□ Glare Problems	□ Itching/Burning Eyes	□ Other _____
□ Cataracts	□ Problems Reading	□ Dry Eyes	□ Other _____

Do you currently have any problems in the following areas? If yes, please provide additional information

	YES	NO	DETAILS
General: Fever, weight loss/gain, etc.			
Ear, Nose, & Throat: Hard of Hearing, runny nose, etc.			
Cardiovascular: High BP, racing pulse, etc.			
Respiratory: Congestion, shortness of breath			
Gastrointestinal: Stomach problems, constipation, etc.			
Genitourinary: Painful or frequent urination, impotence, etc.			
Females: Are you pregnant or nursing?			
Musculoskeletal: Joint pain, cramps, arthritis, etc.			
Skin: Pimples, warts, growths, rash, etc.			
Neurological: Numbness or seizures, etc.			
Psychiatric: Anxiety, depression, insomnia, etc.			
Endocrine: Diabetes, thyroid problems, etc.			
Blood/Lymph: Bleeding disorders, anemia, etc.			
Allergic / Immunological: Sneezing, swelling, etc.			
Have you ever had a blood transfusion?			

Family History: Please circle all that apply

Diabetes, Blindness, Cataracts, Glaucoma, High BP, Heart Disease, Stroke, Cancer, Thyroid Disease Arthritis

Social History:

Do you drink alcohol? Yes No If Yes, Frequency: _____#per ___ Day __ Week __Month
Do you smoke/Former smoker? Yes No If Yes, Frequency: _____#packs per ___ Day __ Week __Month

Physician's Signature _____ Date _____