ATLANTA EYE
PROSTHETICS, INC.

Registration:

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: Work: Cell:	How did you hear of us?
Address 2	Email:	

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact Phone	Pharmacy	Pharmacy Phone

Physician **Family Physician** **Referring Physician**

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

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Atlanta Eye Prosthetics, Inc. 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 heatlhcare operations.

Signature X	Signature Date	Phone Email

Please attach all pertinent insurance ID Cards for photocopying.