

GAINESVILLE EYE ASSOCIATES  
2061 BEVERLY ROAD  
GAINESVILLE, GA 30501  
TELEPHONE (770) 532-4444

REFERRED BY \_\_\_\_\_ DATE \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ SS # \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: M \_\_\_\_\_ F \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

TELEPHONE: HOME: \_\_\_\_\_ BUSINESS \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

PLEASE CHECK ONE: SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ DIVORCED \_\_\_\_\_ WIDOW \_\_\_\_\_

PATIENT EMPLOYED BY: \_\_\_\_\_

SPOUSE NAME: \_\_\_\_\_ EMPLOYED BY: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ PHONE: \_\_\_\_\_

**IF CHILD:**

FATHER'S NAME: \_\_\_\_\_ EMPLOYED BY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_ EMPLOYED BY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

**PRIMARY CARDHOLDER:** \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

**SOCIAL SECURITY NO.** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ PHONE: \_\_\_\_\_

NEAREST RELATIVE NOT LIVING AT YOUR ADDRESS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ POLICY# \_\_\_\_\_

MEDICARE NUMBER: \_\_\_\_\_ MEDICAID # \_\_\_\_\_

YOU MAY COMMUNICATE WITH THE FOLLOWING INDIVIDUALS REGARDING MY CONDITION OR COURSE OF TREATMENT:

SPOUSE  CHILD  OTHER: \_\_\_\_\_  NO ONE

MAY WE LEAVE APPOINTMENT REMINDERS, ETC. ON YOUR ANSWERING MACHINE OR VOICE MAIL?

YES  NO (IF NO, PHONE NUMBER TO CONTACT: \_\_\_\_\_)

\_\_\_\_\_  
PATIENT OR PARENT/ GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE