Phone 770.948.0036

Fax 770.948.0090

# Welcome To Tulman Eye Group

ADULT & PEDIACTRIC OPTOMERY

www.tulmaneyegroup.com

***We are pleased you have chosen us for your eye care. It is our policy to provide you with the best eye health and vision care possible.***

***Again, welcome to our practice, we are here to be of service to you, your relatives, friends and neighbors when the need for eye care arises.***

Miss / Ms. / Mrs. / Mr. / Other_____

**PATIENT INFORMATION** Sex: M / F SS Number____-___-_____

Last_____ First_____ Middle Initial_____

Nickname_____ Date of Birth ___/___/_____

Address_____ Apt_____

City_____ State_____ Zip_____

Phone Home _____ Bus_____ Cell_____

E-Mail_____

Preferred Mode of Contact Phone____ Email_____ Postal____

Employer_____ Phone_____

**In Case of an Emergency** Name_____

Phone_____ Relationship_____

Whom may we thank for referring you to us?_____

**IF CHILD** Mother / Father / Grandparent / Other_____

Name Last_____ First_____ Phone_____

I give my permission for the doctor(s) at Tulman Eye Group to make any decisions regarding examinations, diagnosis and treatment of the above minor.

**Signature X_____ Date_____**

**Payment is due at the time of services are rendered** A finance charge of 1.5% PER MONTH (18% PER YEAR) will be applied on unpaid balances greater than 30 days. Please feel free to discuss our policies and fees with us. We strive to be responsive to our patients needs and concerns.

**MEDICAL INSURANCE**

Primary Insurance_____

Name of Policy Holder: _____

Date of Birth for Policy Holder ___/___/____ SS# of Policy Holder _____

Address if different than Patient _____

_____

Insured Phone # _____ Relationship to Patient _____

**AUTHORIZATION**

I authorize payment of medical/vision benefits to the physician or supplier of services rendered. I authorize release of any medical information necessary to process any claims and also certify that the information contained herein is correct.

**Signature X_____ Date_____**

**NOTICE OF PRIVACY PRACTICES**

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) I have been offered to review or obtain a copy of Tulman Eye Group's (Notice of Privacy Practice) **Signature X**_____ Date___/___/___

I Authorize Tulman Eye Group to release and discuss any and all of my medical health, vision health and materials to the following people:

Name _____

Relationship_____ Phone_____

Name _____

Relationship_____ Phone_____

**Signature X_____ Date_____**