EYE CONSULTANTS OF ATLANTA
OPERATION SAVING SIGHT APPLICATION

______________________	______________	______________________
Applicant's Name	DOB	Social Security

______________________	______________________
Home Phone	Mobile Phone

______________________	______________	________	__________
Street Address	City	State	Zip Code

EYE CARE SERVICES OR PROCEDURES REQUESTED

What is your current eye problem? Please include a copy of your doctor's findings or have notes faxed to our office. (404-351-7070). List other medical conditions: ______________________________________

____

Patient must be available for at least 60 days after surgery for postoperative care.

HOUSEHOLD INFORMATION
(Please list your spouse, children, parents, or other dependents)

Housing status ☐ Rent Other______________________________________

☐ Own

☐ Staying with someone

First & Last Name __________________ Relation to patient_____________ Age _______ Employment Status ☐ Employed ☐ Not Employed ☐ N/A

First & Last Name ____________________ Relation to patient _____________ Age ________ Employment Status ☐ Employed ☐ Not Employed ☐ N/A

First & Last Name ____________________ Relation to patient______________ Age _________ Employment Status ☐ Employed ☐ Not Employed ☐ N/A

First & Last Name ____________________ Relation to patient______________ Age ___________ Employment Status ☐ Employed ☐ Not Employed ☐ N/A

HOUSEHOLD INCOME AND EMPLOYMENT INFORMATION

1) Patient:

Name: ______________________________________

Employer: ____
Wages/Tips (Before Taxes)

$ ______________________________

☐ Hourly
☐ Weekly
☐ Bi-Weekly
☐ Monthly
☐ Yearly

Occupation _________________________

Average hours worked per week _______

OTHER INCOME

Unemployment: $ ________________ /week

Social Security: $ ________________ /month

Supplemental Security Income (SSI): $ ________________ /month

Pension/Retirement: $ ______________________ /month

Child or Spousal Support: $ _______________________________ /month

Other: $ _______________________________

2) Additional Wage Earner

Name: ____

Employer: ______________________________________

Wages/Tips (Before Taxes)

$ _______________________________

☐ Hourly
☐ Weekly
☐ Bi-Weekly
☐ Monthly
☐ Yearly

Occupation _______________________

Average hours worked per week_____

OTHER INCOME

Unemployment: $ _____________________ /week

Social Security: $ ____________________ /month

Supplemental Security Income (SSI): $ _____________________________ /month

Pension/Retirement: $ ______________________________ /month

Child or Spousal Support: $ __________________________________ /month

Other: $_____________________________________/month

PATIENT INSURANCE INFORMATION

Does patient have insurance? ☐ Yes ☐ No

If no, have they applied for state medical assistance? ☐ Yes ☐ No

Reason for ineligibility (if applicable)_______________
(Please provide copy of denial)

If patient has insurance list plan name: _________________________ Policy Number: ____________ Group Number ___________

HOUSEHOLD MONTHLY BILLS/OBLIGATIONS

Please list all of your monthly bills or payment arrangement obligations for patient and household. These may include but are not limited to: mortgage/rent, utilities (gas, electrical, water), cable, phone service, internet, car payments and insurances, credit card balances & monthly payments, medical bills, medications, child or spousal support etc.

Type of Bill/Obligation	**Monthly $ Amount**	**Is patient directly responsible for full/partial payment?**	
MORTGAGE/RENT	_____________________	☐ Yes ☐ No	$__________________ if partial
UTILITY - GAS	_____________________	☐ Yes ☐ No	$__________________ if partial
UTILITY – ELECTRIC	______________________	☐ Yes ☐ No	$__________________ if partial
UTILITY – GARBAGE	______________________	☐ Yes ☐ No	$__________________ if partial
UTILITY – WATER/SEWER	______________________	☐ Yes ☐ No	$__________________ if partial
PHONE – CELL/OTHER	______________________	☐ Yes ☐ No	$__________________ if partial
CABLE/INTERNET	______________________	☐ Yes ☐ No	$__________________ if partial
CAR PAYMENT	______________________	☐ Yes ☐ No	$__________________ if partial
MEDICAL BILLS-PATIENT	______________________	☐ Yes ☐ No	$__________________ if partial
MEDICAL BILLS-OTHER MEMBERS	______________________	☐ Yes ☐ No	$__________________ if partial

MEDICATIONS-PATIENT	______________________	☐ Yes ☐ No	$________________	if partial
MEDICATIONS-OTHER MEMBERS	_______________________	☐ Yes ☐ No	$________________	if partial
CREDIT CARD DEBIT	_______________________	☐ Yes ☐ No	$________________	if partial
OTHER	________________________	☐ Yes ☐ No	$________________	if partial
OTHER	________________________	☐ Yes ☐ No	$________________	if partial

OTHER EXTENUATING CIRCUMSTANCES IMPACTING YOUR FINANCIAL STATUS/SUMMARY OF WHY YOU FEEL YOU SHOULD BE CONSIDERED A CANDIDATE FOR FREE EYE SURGERY:

____

____

____

____

____

____

I declare that all parts of this application are true and correct statements, to the best of my knowledge. I understand that the details of this application are solely used to determine my overall financial status and possible eligibility for Operation Saving Sight.

_______________________________________ _______________________________

Patient Signature Date

PLEASE SEND COMPLETED FORM TO:

Eye Consultants of Atlanta
Diane at Operation Saving Sight
3225 Cumberland Blvd, SE, Suite 900
Atlanta, GA 30339