

Allatoona Eye Clinic - Eye M.D.s

962 Joe Frank Harris Parkway, S.E.

Suite 201

Cartersville, GA 30120

Jeffrey R. Brant, M.D.

Feng Zhao, M.D.

PATIENT INFORMATION

Welcome To Our Office

(Please complete this entire form- please print)

Date _____

Patient's Name _____			
Mailing Address & Street Addresss if P.O. Box _____		(Street)	(City) (State) (Zip)
Social Security # _____		Home Phone _____	
Date of Birth _____	Age _____	Sex _____	Cell Phone _____
Employer's Name _____		Bus.Phone # _____	Ext # _____
Occupation _____		How Long Employed _____	
Employer's Address _____		(Street)	(City) (State) (Zip)
Primary Care Physician's Name & Address _____		Phone# _____	
Guardian/Spouse Information Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Other			
Spouse or Parent's Name _____		Social Security # _____	
Spouse or Parent's Employer _____		Phone _____	
Employer's Address _____		(Street)	(City) (State) (Zip)
Occupation _____		How Long Employed _____	
Emergency Contact (Other than Spouse or anyone living with you.)			
Name _____		Relationship _____	Phone _____
Address _____		(Street)	(City) (State) (Zip)

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICES. IF HOSPITALIZATION IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION.

Primary Insurance			
Name of Policy Holder _____			
Relation to Patient _____		Birthdate _____	S.S.# _____
Address (if different from patient's) _____		(Street)	(City) (State) (Zip)
Insurance Company _____			
Member ID # _____		Group # _____	
Additional Insurance			
Name of Policy Holder _____			
Relation to Patient _____		Birthdate _____	S.S.# _____
Address (if different from patient's) _____		(Street)	(City) (State) (Zip)
Insurance Company _____			
Member ID # _____		Group # _____	
ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPERS.			

Please Continue On Reverse Side

