

# 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., Ph.D.

Kristen Peterson, M.D.

## PATIENT INFORMATION

(Please complete this entire form- please print)

Date \_\_\_\_\_

*Welcome To Our Office*

Patient's Name \_\_\_\_\_

Mailing Address & \_\_\_\_\_  
Street Addresss if P.O. Box (Street) (City) (State) (Zip)

Last 4 of Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer's Name \_\_\_\_\_ Bus.Phone # \_\_\_\_\_ Ext # \_\_\_\_\_

Current Occupation (or previous if retired) \_\_\_\_\_ How Long Employed \_\_\_\_\_

Employer's Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Primary Care Physician's Name & Address \_\_\_\_\_ Phone# \_\_\_\_\_

**Guardian/Spouse Information** Marital Status:  Single  Married  Divorced  Widowed  Separated  Other

Spouse or Parent's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Spouse or Parent's Employer \_\_\_\_\_ Phone \_\_\_\_\_

Employer's Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Current Occupation (or previous if retired) \_\_\_\_\_ 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. PATIENT IS RESPONSIBLE FOR PROVIDING CURRENT INSURANCE INFORMATION.**

## AUTHORIZATION INFORMATION

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize payment of medical benefits to the physician or supplier for services described.

Signed: \_\_\_\_\_

**I authorize this organization to discuss my condition with the person/s listed. Yes [ ] No [ ]**  
**Person/s:** \_\_\_\_\_

**I authorize this organization to leave a message on my voice-mail. Yes [ ] No [ ]**

\$25 Late fee for Missed/Late Cancel Appts. All non-covered insurance items are patient's responsibility

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Please Continue On Reverse Side**

I acknowledge that Allatoona Eye Institute has provided me with a copy of its Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signature \_\_\_\_\_ Date \_\_\_\_\_

**ALLATOONA EYE CLINIC**

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*Board Certified Ophthalmologists*

**(Please complete BOTH sides)**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Main Eye Complaint(s) and/or Reason for Visit: \_\_\_\_\_

\_\_\_\_\_

Other (Previous) Eye Problems: \_\_\_\_\_

Eye Medications: \_\_\_\_\_

Do you wear glasses?  YES  NO Contact lenses?  YES  NO

Is there a family history of glaucoma?  YES  NO Macular degeneration?  YES  NO

Other Medications: \_\_\_\_\_

\_\_\_\_\_

Have you ever taken prostate meds?  YES  NO If so, which meds: \_\_\_\_\_

\_\_\_\_\_

Medical Problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

Do you smoke or use tobacco products?  YES  NO If so, how much? \_\_\_\_\_

Have you smoked in the past?  YES  NO When did you quit? \_\_\_\_\_

Do you drink alcohol?  YES  NO If so, how much? \_\_\_\_\_

If you quit drinking alcohol, when did you quit? \_\_\_\_\_

Do you or have you ever used "street drugs?" \_\_\_\_\_

Occupation (if retired, previous occupation): \_\_\_\_\_

If new patient, who referred you? \_\_\_\_\_

Who is your primary care doctor? \_\_\_\_\_

Are you retired?  YES  NO Marital status:  Married  Single  Divorced  
 Separated  Widowed

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Review of Systems (Please answer the following questions)

## RESPIRATORY

- Breathing difficulty?  NO  YES  
Sleep apnea?  NO  YES  
COPD or asthma?  NO  YES

## CIRCULATORY

- Coronary artery disease?  NO  YES  
Congestive heart failure?  NO  YES  
Heart arrhythmia?  NO  YES  
Heart attack?  NO  YES  
Heart valve disease?  NO  YES  
High blood pressure?  NO  YES  
High Cholesterol?  NO  YES

## ENDOCRINE

- Thyroid disease?  NO  YES  
Type 1 diabetes?  NO  YES  
Type 2 diabetes?  NO  YES  
Borderline diabetes?  NO  YES

## DIGESTIVE

- "Heartburn?"  NO  YES  
Ulcers?  NO  YES  
Liver disease?  NO  YES  
Gall stones?  NO  YES  
Gall bladder surgery?  NO  YES

## MUSCLES/BONES/JOINTS

- Rheumatoid arthritis?  NO  YES  
Artificial joints?  NO  YES  
Osteoarthritis?  NO  YES  
Restless leg syndrome?  NO  YES  
Gout?  NO  YES

## CANCER

- Have you had cancer?  NO  YES  
If so, what type(s)? \_\_\_\_\_  
\_\_\_\_\_

## ANESTHESIA

- Have you had problems with anesthesia?  
 NO  YES

## HEMATOLOGY (BLOOD)

- Anemia?  NO  YES  
Bleeding/Bruising?  NO  YES  
HIV or AIDS?  NO  YES

## URINARY

- Prostate disease (Men)?  NO  YES  
Kidney stones?  NO  YES  
Blood in urine  NO  YES

## NEUROLOGICAL / PSYCHIATRIC

- Convulsions/Seizures?  NO  YES  
Stroke?  NO  YES  
Paralysis?  NO  YES  
Numbness?  NO  YES  
Psychiatric condition?  NO  YES  
Clinical depression?  NO  YES  
Anxiety?  NO  YES