Dr. Kenneth G. Schneider O.D., P.C.
72 Falls Road
Toccoa, Georgia 30577
706-886-2120

Welcome To Our Office

Date:____________________ Social Security No:______________________________________

Patients Name:____

Address:____

City:______________________________State:__________________________Zip:___________________________

Home Phone:_________________________Mobile:________________________Work:_________________________

Sex:__________________Age:________________Birthday:____

Marital Status: Married:____________ Single:____________ Widowed:______________Divorced:____________

Spouse's Name____

Patient's parents Name(if minor)____

Person Responsible for Bill:_________________________________Relationship:____________________________

Address if Different:____

City:______________________________State:__________________________Zip:___________________________

Patient's Employer:______________________________Spouse's Employer________________________________

Patient's Insurance Company:_______________________________Member ID:____________________________

Spouse's Insurance Company:_______________________________Member ID:____________________________

Medicare No:____Deductible Met?_____________________________

Supplement Insurance Company:_________________________________Member ID:_________________________

I Authorize Kenneth G. Schneider O.D.,P.C. to release to my insurance company any information required for servies provided.
I understand that I remain responsible to Kenneth G. Schneider O.D.,P.C. for any and all charges.
I Authorize payment of medical benefits to Kenneth G. Schneider O.D.,P.C.

Signature____