Welcome to Our Office

Mark A. Gottlieb, O. D.
Sharper Vision
3820 Pleasant Hill Rd. NW, Ste 5
Duluth, GA 30096
770) 476-9585

Appointment Date ______________

Patient's Name (Please Print)________________________________Birth Date ____________

M or F ________ SSN ________________________________

Spouse____________________________

If a Child, <u>Both</u> Parent's Name____

Street Address____

City ____________________________ State __________ Zip Code ______________

Home Phone _______________________ Work Phone/Cell Phone _____________________

E-mail Address____

Employer _______________________ Occupation _______________________________

Name Insured _________________________ Work Phone _____________________

Birth Date ___________ Relationship ____________SSN ___________________

Insurance Co. _____________________Policy # ________________Group #________

Insurance Address___________________________City/State/Zip_________________

Insurance Phone _____________________

How did you find out about our office ____

Emergency Contact __________________________ Phone #_________________________

Date of Last Exam ________ Name of Previous Eye Doctor ____________________________

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due at the time services are rendered.

Signature ____________________________________ Date ________________