Gerald K. Brantley, MD
Terry E. Ham, MD
1023 Keith Drive
Perry, Georgia 31069

PATIENT INFORMATION *(Please Print)*

Patient Name: ______________________________ SS #: ______________ DOB: __________
First Middle Last

Home Address: ______________________________ City: ______________ State: _____ Zip: _____

Home Phone: (____) ______-______ Cell Phone: (____) ______-______ Email: __________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow

Employed By: ______________________________ Work Phone: (____) ______-______

Work Address: ______________________________ Occupation: ______________________

Spouse/Parent: ______________________________ DOB: ______________________
First Middle Last

Work Address: ______________________________ Work Phone: (____) ______-______

Emergency Contact: __________________ Relation: ______________ Phone: (____) ______-______

Pharmacy: __________________ Phone: (____) ______-______ Last Doctor: ______________

Whom May We Thank For This Referral? ____

INSURANCE INFORMATION *(Please Print)*

All payments are due at the time of service. If hospitalization is indicated, the patient is responsible for notifying this office if a second opinion and/or pre-certification is required before admission.

Method of Payment: ❑Cash ❑Check/Debit ❑MC/Visa/Am Ex/Discover ❑Insurance (fill out below)

PLEASE GIVE RECEPTIONIST A COPY OF YOUR CURRENT INSURANCE CARD AT THE TIME OF YOUR APPOINTMENT.

Policy Name: ______________________________ Policy #: ______________________

Group Name/Number: ______________________________ Address: ______________________

Policy Holders Name: ______________________________ Policy Holders DOB: ______________________

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Gerald K. Brantley and/or Terry E. Ham, Jr. to furnish information to the insurance carriers concerning my illness and treatments and I hereby assign to the physician (s) all payments for medical services rendered to myself or my dependents. ***I understand that I am responsible for any amount not covered by insurance.*** I further agree that in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees should this be required.

I understand the importance of current billing information and know it is my responsibility to keep this office informed of any changes in my insurance company or personal billing address. I realize any claims that are denied or delayed for timely filing due to this information not being updated are my responsibility. By signing below, I verify the information above is correct and current as of the date indicated below.

Date: ______________________________ Signature of Patient: ______________________________

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