Dr. Pat Robinson

PATIENT REGISTRATION FORM

Last Name: _____ **First name:** _____ **Middle initial:** ____ **Date**: ____/_____/_____

Address: _____ City: _____ State: _____ Zip code: _____

Cell phone: _____-_____-_____ Home: _____-_____-_____ Work: _____-_____-_____

Social security #: _____-_____-_____ Date of birth: ____/_____/_____ Age: _____

Marital status (circle one): Single Married Separated Divorced

Email address: _____ May we occasionally email you with topics of interest? Yes No

How did you hear about us? Online Print ad Insurance list Referral (Whom may we thank?) _____

Emergency contact: _____ Relationship: _____

Cell phone: _____-_____-_____ Home: _____-_____-_____ Work: _____-_____-_____

Primary care physician: _____ Phone: _____-_____-_____

Preferred pharmacy: _____ Address: _____ Phone: _____-_____-_____

Patient's employer name: _____ Position: _____

Address: _____ City: _____ State: _____ Zip code: _____

Circle one: Spouse Partner Guardian

Name: _____ SS#: _____-_____-_____ Date of birth: ___/___/____

Address: _____ City: _____ State: _____ Zip code: _____ Age: _____

Cell phone: _____-_____-_____ Home: _____-_____-_____ Work: _____-_____-_____

Employer name: _____ Address: _____ City: _____ State: ____ Zip: _____

INSURANCE INFORMATION: Please provide all pertinent information regarding your insurance coverage. If you have coverage with more than one carrier, supply information for both carriers. Please list all numbers on your card(s). You are responsible to know your insurance coverage and your financial responsibilities as they relate to your coverage. Please check with your insurance carrier for co-insurance, co-pay, and deductible (in or out of network).

Primary insurance plan: _____ Self Spouse Child Policy#: _____ Group# _____

Co-pay Amount: _____ Subscriber name: _____ Relationship to patient: _____

Subscriber address: _____ City: _____ State: _____ Zip code: _____

Secondary insurance plan: _____ Self Spouse Child Policy#: _____ Group#: _____

Co-pay Amount: _____ Subscriber name: _____ Relationship to patient: _____

TO MY INSURANCE CARRIER(S):

I authorize the release of any medical information necessary to process my insurance claim(s) to Cure, MD. I authorize and request payment of medical benefits directly to my physician, L. Pat Robinson, MD. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in lieu of the original. I agree to pay all charges not covered by my insurance carrier(s). These charges include but are not limited to deductibles and copayments of my insurance policy.

Patient signature _____ Date ____/____/_____