PATIENT REGISTRATION

Name:_____ _____ _____
Last First Middle
Date of Birth:_____ Social Security#:_____
Marital Status: □M □S □D □W
Email Address:_____
Home Address:_____
(Street and / or PO Box)
City:_____State:_____Zip:_____
Home Telephone:_____ Mobile Telephone:_____
Employer Name:_____ Work: Telephone:_____
Employer Address:_____
(Street and / or PO Box)
City:_____State:_____Zip:_____

PRIMARY INSURANCE

(Must provide copy of insurance card)

Insurance Company Name: _____
Subscriber's Name:_____
Subscriber's Date of Birth:_____
Subscriber's Social Security#:_____
Subscriber's Employer:_____
Employer Address:_____
City:_____State:_____Zip_____

SECONDARY INSURANCE

(if applicable)

Insurance Company Name:_____
Subscriber's Name:_____
Subscriber's Date of Birth:_____Subscriber's Social Security#:_____
Subscriber's Employer:_____
Employer Address:_____
City:_____State:_____Zip:_____

ASSIGNMENT OF BENEFITS

I hereby assign all medial and/or surgical benefits: to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurances, and any other health plans, to: DAVID J. PATTON, MD., INC. This assignment will remain in effect until revoked by me in writing.

I understand that I am financially responsible for any balance and / or co-pay not covered by my insurance carrier(s) for services rendered.
I hereby authorize the release of any medical information necessary to process a claim with my insurance carrier(s) in securing payment of benefits.

_____