FORM 1

DRS. MOORE & STOCKSTILL, P.C.

Patient Registration Form

Referring Physician _____

How did you find us: Newspaper (name) _____ Magazine (name) _____

Website / Facebook / Friend / Family / Radio / Billboard / Other _____

Title: (please circle) Dr. Mrs. Ms.

PATIENT NAME: Last _____ First _____ Middle _____

Address _____ City_____ State _____ ZIP _____

Email: _____

Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Birth Date: ____ ____ - ____ ____ - ____ ____

Marital Status _____ Home Phone (_____) _____

Cell Phone (_____) _____ Work Phone (_____) _____

PREFERRED PHONE _____ OK TO LEAVE MESSAGE: (circle) Yes No

Employer _____ Address _____ City/ State _____ /____

Emergency Contact Name _____ Phone Number (____)_____ Relation _____

<u>RESPONSIBLE PARTY</u> (please circle) Self / Other

Guarantor Name (if other) _____ Phone Number (_____)_____

Address (if different from above) _____ City _____ State____ ZIP _____

Relation to Patient _____ Guarantor Employer _____

Employer Address: City _____ State _____ ZIP _____

Guarantor SSN # ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Guarantor Birth Date ___ ___ - ___ ___ - ___ ___

<u>PRIMARY</u>
Name of Insurance Company _____ Policy Holder _____
ID Number _____ Group Number _____
<u>SECONDARY</u>
Name of Insurance Company _____ Policy Holder _____
ID Number _____ Group Number _____

I hereby authorize Drs. Moore & Stockstill, P.C. , to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Drs. Moore & Stockstill, P.C., of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original. I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Patient's signature (or responsible party) _____ Date _____