PATIENT REGISTRATION

DATE _____

PATIENT FULL NAME	FIRST					
ADDRESS						
CITY	_STATE	ZIP	HOME PHO	NE		
Your Social Security Number	Referring Physician					
DATE OF BIRTH	MARITAL		. STATUSSEX		AGE	
************	********	*******	**********	********	******	
INSURANCE INFORMATION						
DO YOU HAVE MEDICARE?		MED	MEDICARE NUMBER			
PRIMARY INSURANCE		SEC	SECONDARY INSURANCE			
NAME OF COMPANY		NAM	NAME OF COMPANY			
POLICYHOLDER		POLI	POLICYHOLDER			
CERTIFICATE #	RTIFICATE #		CERTIFICATE #			
PLEASE CIRCLE THE PHYSICIAN	I YOU ARE GC	ING TO SEE:				
ANDERSON BALAN	KIM	КОНИТ	MACKENZIE	ORR	PANG	
PHARR RAMAC	HANDRAN	ROWE	TYSINGER	ZIEMINSKI		
EMPLOYED BY:	ADDRESS		PHONE _	<u></u>		
Who is responsible for the bill?						
Address						
Spouse's Name	Spouse's Employer					
Address	Phone					
Emergency Contact			Phone			
*************	*******	*********	********	******	*****	
I AUTHORIZE THE RELEASE OF	ANY MEDICAL	INFORMATION	NECESSARY TO PR	OCESS MY INS	URANCE	
Signed			Date			
I AUTHORIZE MY INSURANCE COI OF SERVICES, GREENSBORO M			F ANY MEDICAL BENE	EFITS TO THE PI	ROVIDER	
Signed			Date	····		

I understand that I am financially responsible for my medical care. My insurance will be filed as a courtesy.