



PATIENT REGISTRATION FORM

Chart # \_\_\_\_\_

Date: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Birth Place: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Length of Employment: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

**Children**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ | Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ | Name: \_\_\_\_\_ Age: \_\_\_\_\_

Emergency Notification other than spouse: Name: \_\_\_\_\_ Phone No. \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Last Physical Exam: \_\_\_\_\_

Primary Insurance Co. \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Sex: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Relationship to Patient:  SELF  SPOUSE  PARENT

Effective Date: \_\_\_\_\_ First ID No. \_\_\_\_\_ Second ID No. \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Sex: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Relationship to Patient:  SELF  SPOUSE  PARENT

Effective Date: \_\_\_\_\_ First ID No. \_\_\_\_\_ Second ID No. \_\_\_\_\_

**PAYMENT AGREEMENT**

I AGREE TO PAY WILLIAMS, BENAVIDES & MARSTON, M.D., P.A. FOR ANY SERVICES NOT COVERED BY MY INSURANCE COMPANY. I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION TO THE ABOVE INSURANCE CO. AND AUTHORIZE PAYMENT DIRECTLY TO WILLIAMS, BENAVIDES & MARSTON, M.D., P.A.

I UNDERSTAND THERE WILL BE A \$25.00 CHARGE FOR ANY MISSED APPOINTMENT WITHOUT 48 HOURS NOTICE.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_