PATIENT REGISTRATION FORM SODOMA DOWSWELL ANDERSON TODAY'S DATE_____

PATIENT NAME_____ RESPONSIBLE PARTY_____

MAILING ADDRESS_____ CITY,STATE, ZIP_____

YEAR ROUND RESIDENT SEASONAL RESIDENT ALTERNATE ADDRESS_____

HOME PHONE_____ CELL PHONE_____ WORK PHONE_____

GENDER_____ RACE_____ LANGUAGE SPOKEN AT HOME_____

DATE OF BIRTH_____ SOCIAL SECURITY NUMBER_____

EMAIL ADDRESS_____ MARITAL STATUS_____ LEFT OR RIGHT HANDED

PRIMARY CARE PHYSICIAN NAME/PHONE_____

PHARMACY/CROSSTREETS/PHONE_____

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE CO._____	INSURANCE CO._____
CLAIMS ADDRESS_____	CLAIMS ADDRESS_____
INSURED'S NAME_____	INSURED'S NAME_____
RELATIONSHIP_____	RELATIONSHIP_____
POLICY #_____	POLICY #_____
GROUP #_____	GROUP #_____
INSURED DOB_____	INSURED DOB_____
INSURED GENDER_____	INSURED GENDER_____
SPECIALIST COPAY_____	SPECIALIST COPAY_____

HOW DID YOU HEAR ABOUT THIS PRACTICE? NEWSPAPER AD INTERNET AD PCP REFERRED FRIEND YELLOW PAGES

REFERRING PHYSICIAN:_____

EMERGENCY CONTACT: _____

NAME PHONE DOB

IS THS CONTACT AUTHORIZED TO MAKE MEDICAL DECISIONS FOR YOU? **YES** **NO**

Assignment and Release: 1. I hereby assign my insurance benefits to be paid directly to the physician; or, if my current policy prohibits direct payment to the doctor, I instruct and direct my insurance company to make out the check to me and the rendering physician. 2. I also authorize the physician to deposit checks received on the patient's account when made out to the patient. 3. I also authorize the physician to release any information required to process claims or required in the course of my exam and treatment. 4. I hereby agree to pay my account as services are provided. If for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of the monthly statement. 5. I authorize my rendering physician to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature_____ Date_____