PATIENT REGISTRATION FORM

Patient's Name: _____ Date: _____
(Last) (First) (MI)

Home Address: _____
(Street) (City, State) (Zip Code)

Phone Numbers: _____
(Home) (Work) (Cell)

DOB: _____ Age: _____ Social Security: _____EMAIL:_____

Insurance Carrier(member's name): _____
Last First
DOB:_____ Social Security:_____ relation:_____

Person responsible for payment of account: _____
(If patient is a minor or dependent student)

Employer (Patient): _____ Occupation: _____

Spouse/Parent Name: _____ Work Number _____

Social Security #: _____ DOB: _____
Employer: _____ Occupation: _____

Nearest Relative Not Living with you: _____
Phone Number: _____ Relationship: _____

In case of Emergency, please contact: _____

Who may we thank for this Referral? _____

Primary Care Physician: _____ Phone: _____

PCP Address _____ City _____State ___ Zip Code _____

Authorization to Release Information to My Doctor: _____
(Signature of Patient or Guardian)

IN ADDITION TO MY PRIMARY CARE PHYSICIAN, I WOULD LIKE FOR DR. BAXTER TO KEEP THE FOLLOWING DOCTOR(S) INFORMED ABOUT MY ALLERGY TESTING OR VISIT(S) HERE AS SHE DEEMS APPROPRIATE.

(1)_____(2) _____(3)_____

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I ENTITLED (FOR SERVICES RENDERED) INCLUDING MEDICARE AND OTHER GOVERNMENT-SPONSORED PROGRAMS, PRIVATE INSURANCE AND OTHER PLANS TO BARBARA STARK BAXTER, M.D. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. I HEREBY AUTHORIZE BARBARA STARK BAXTER, M.D. TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

_____ _____
SIGNATURE DATE