

PATIENT INFORMATION

____ Michael P. Brown, M.D.
____ Patricia Wyatt-Harris, M.D.
____ Anna Stork-Fury, D.O.
____ Elizabeth Cox, M.D.

DATE: _____

PATIENT'S NAME: _____
FIRST MIDDLE LAST MAIDEN NAME

CURRENT ADDRESS: _____
STREET APT. # CITY STATE ZIP CODE

BIRTH DATE: _____ AGE _____ RACE _____ SS _____
MONTH DAY YEAR

MARITAL STATUS: _____ HUSBAND'S NAME: _____

HOME PHONE: _____ PATIENT'S OCCUPATION: _____

CELL PHONE: _____ EMAIL ADDRESS: _____

PATIENT'S EMPLOYER: _____
COMPANY NAME PHONE NUMBER
ADDRESS

HUSBAND'S EMPLOYER: _____
COMPANY NAME PHONE NUMBER
ADDRESS

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____
(OTHER THAN SPOUSE)

HOW RELATED: _____
ADDRESS PHONE NUMBER

PRIMARY CARE PHYSICIAN: _____

PRIMARY INSURANCE CO. _____
NAME OF INSURANCE CO. EMPLOYER

(CLAIM MAILING ADDRESS) POLICY HOLDER

IDENTIFICATION NUMBER GROUP NUMBER POLICY HOLDER SS NUMBER

POLICY HOLDER BIRTH DATE: _____ GENDER: Male or Female
MONTH DAY YEAR

SECONDARY INSURANCE CO. _____
NAME OF INSURANCE CO. EMPLOYER

(CLAIM MAILING ADDRESS) POLICY HOLDER

IDENTIFICATION NUMBER GROUP NUMBER POLICY HOLDER SS NUMBER

POLICY HOLDER BIRTH DATE: _____ GENDER: Male or Female
MONTH DAY YEAR

I hereby authorize Dr. Brown, Dr. Wyatt-Harris, Dr. Stork-Fury or Dr. Cox to release any records/information needed to process medical/surgical health insurance claims. I also authorize payment of medical/surgical benefits for services performed by Dr. Brown, Dr. Wyatt-Harris, Dr. Stork-Fury or Dr. Cox. I also understand that regardless of insurance coverage, I am responsible for payment for any service that is provided by Dr. Brown, Dr. Wyatt-Harris, Dr. Stork-Fury or Dr. Cox. A copy of this authorization is as valid as the original.

SIGNATURE DATE