

**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