T. SCOTT WEBB, D.O. PATIENT REGISTRATION

PATIENT INFORMATION

NAME: ____________________________ ___________________ ____
(FIRST) (MI) (LAST)

DOB: ____/____/_______ SS#: __________-_____-_________ SEX: ☐ MALE ☐ FEMALE

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

ADDRESS: ____ (APT) __________

CITY: ____ ST___________ ZIP: __________________

PHONE: (_____) _______________ CELL: (_____) _______________ WORK: (____) _______________

EMPLOYER: ____

PHARMACY ____

INSURANCE

☐ I DO NOT HAVE INSURANCE/ CASH PAYMENT

PRIMARY INSURANCE: ___________________________________SECONDARY INSURANCE: ____

POLICY HOLDER NAME: _______________________________________ DOB: ____/____/_______ SS#: __________-_____-_________

EMAIL AUTHORIZATION

OUR OFFICE WOULD LIKE TO UTILIZE E-MAIL TO COMMUNICATE WITH YOU IF THIS IS CONVENIENT FOR YOU AND IF YOU FEEL COMFORTABLE WITH THIS. E-MAIL WILL ONLY BE USED IF YOU SIGN THE AUTHORIZATION BELOW. WE FEEL THAT E-MAIL MAY BE ESPECIALLY USEFUL TO GIVE TEST RESULTS OR TO REMIND YOU OF UPCOMING LAB OR APPOINTMENTS.

__________ YES, I AGREE TO COMMUNICATION VIA E-MAIL FROM MAFP

MY E-MAIL ADDRESS IS____
(PLEASE PRINT ADDRESS CAREFULLY)

__________ NO, I DO NO WANT TO RECEIVE E-MAIL FROM MAFP

_______________________________ _______________________________ DATE: ____/_____/____
(PLEASE PRINT NAME) *(CONSENTING SIGNATURE)*

SCHEDULING/ CANCELATION

OUT OF RESPECT TO OTHER PATIENTS WE REQUEST YOU KEEP YOUR APPOINTMENTS. IN THE EVENT YOU NEED TO CANCEL OR RESCHEDULE, PLEASE GIVE **NO LESS THAN 24 HOUR NOTICE.**

OUR CLINIC CONSIDERS 3 TOTAL NO SHOWS OR SAME DAY CANCELLATIONS WITHIN A YEAR, GROUNDS FOR DISMISSAL FROM THE CLINIC.

PATIENT INITIALS ___________________________

EMERGENCY CONTACT

NAME: ____RELATIONSHIP______________________________

ADDRESS: ____ (APT) __________

CITY: ____ ST___________ ZIP: __________________

PHONE: (_____) _______________ CELL: (_____) _______________ WORK: (____) _______________

I hereby give lifetime authorization for payment of insurance benefits to be made directly to MAFP, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.
I further agree that a photocopy of this agreement shall be as valid as the original.
I understand that MAFP is not a lending institution. After my insurance has been billed and taken action, I will pay any balance in full upon receipt of my statement.

DATE: __________________________YOUR SIGNATURE: ____