**George A. Patterson III M.D. – New Patient Registration Form (2023)**

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sex** (Please circle) **Male Female**

**Marital Status** (Please circle) **Married Single Divorced Widowed**

**Home Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Work Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Street Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Apt** \_\_\_\_\_\_\_\_\_\_

**City**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State** \_\_\_\_\_\_\_\_\_\_\_ **Zip**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer/School**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Occupation**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please circle) **Part-time Full-time Student Retired**

**Emergency Contact (Name)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Emergency Contact (Relationship)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact (Phone Number)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referred by** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Medical Doctor** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s relationship to insured** (Please circle) **Self Spouse Child Other** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If you are NOT the primary policy holder, please fill out the subscriber’s information marked with “ \*\* ”*

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**\*\*Name of Subscriber \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*\*Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*I hereby authorize George A. Patterson, III, MD to apply for benefits on my behalf for covered services. I certify that the information I have reported is correct and further authorize the release of any necessary information including medical information to this or any related claim. All accounts are due in full 30 days after the insurance has paid. There will be a $40.00 charge for any checks returned by our bank. If your account is unpaid after 90 days, it will be sent to our attorney for collection. You will then be responsible for collection costs including attorney fees, court costs and expenses related to reporting the account to the credit bureaus.*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Subscriber or Beneficiary**  **Date**