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Brian Stephens, M.D., F.A.C.O.G.
Lisa Graessle, Nurse Practitioner

PATIENT REGISTRATION

PLEASE PRINT

Dr. _____

Appt. Date _____

Primary Care Physician _____

Patient Name _____
(Last) (First) (Middle) (Maiden)

Address: _____

City, State, Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Patient's Soc. Sec. # _____ - _____ - _____ Date of Birth _____ - _____ - _____

Marital Status: Single Married Divorced Widowed

Patient's Employer: _____ Address: _____

Work Phone: (____) _____ Extensions _____ Occupation: _____

Spouse: _____ Cell Phone: (____) _____ Soc. Sec. # _____ - _____ - _____ Date of Birth _____ - _____ - _____

Spouse's Employer _____ Work Phone: (____) _____

Contact Person (not living with you)

Name _____ Relationship _____

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

Please fill out this section if responsible party is other than patient.

Name: _____ Soc. Sec. # _____ - _____ - _____

Address: _____

Home Phone Number: (____) _____ Birthdate: _____ How Related: _____

Employer: _____ Work Phone Number: (____) _____

Authorization

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Relations pertaining to Medicare/Medicaid assignment of benefits apply. I understand that I am financially responsible for all charges not covered by this authorization.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN IF PATIENT IS A MINOR:

X _____ Date _____