PATIENT REGISTRATION FORM

OWEN R. BELL, MD, APC✧Wendy Thon, ANP✧Martha Linden, CNM

Patient Information

Patient's Name: _____Birthdate:_____Age:_____

Mailing Address: _____City:_____State:_____Zip:_____

Physical Address: _____City:_____State:_____Zip:_____

Social Security Num. _____Driver's License: _____State:_____

(This information is used for identification purposes only and will be kept confidential)

Preferred pharmacy: _____Primary Language_____

Employer: _____Occupation:_____

Highest school grade completed: _____Marital status: _____Race/Ethnicity: _____

Contact Information

Phone numbers: Home: _____ Work: _____ Cell: _____Email:_____

Best Number to reach you: ☐ Home ☐ Work ☐ Cell Referred by: _____

Emergency contact:_____Contact No. _____

Nearest relative: _____Contact No. _____

Spouse ☐ Partner ☐ Information: (Please check one)

Name: _____Birthdate:_____

Social Security Num. _____ Employer: _____Phone No._____

Insurance Information:

Insurance Company: _____Policy holder: _____DOB: _____

Do you have a secondary insurance? YES ☐ NO ☐

Insurance Company: _____Policy holder: _____DOB:_____

To whom may we give laboratory/medical reports?

Self Only: ☐ Name: _____Relationship:_____

May we call you at work to advise you of laboratory/medical reports? YES ☐ NO ☐

I authorize Dr. Owen Bell to furnish information to insurance carriers concerning my medical records. I assign to Dr. Owen Bell all payments for medical services rendered to me. I understand that I am responsible for any amount not covered by insurance.

I HAVE HAD AN OPPORTUNITY TO REVIEW THE NOTICE OF PRIVACY PRACTICES FOR OWEN R. BELL, MD, APC

SIGNATURE: _____ DATE: _____