Patient Information

Name ______________________________________ Marital Status oS oM oW oD

SS#____ DOB _______________________________________

Address ____________________________________ Cell No. ____________________________________

____ Home No. ___________________________________

Email ______________________________________ Work No. ___________________________________

Gender__________________________ Employer ___________________________________

Age_____________________________ Position ____________________________________

Spouse or Parent Name ________________________ Address ____
Phone No.__________________________

Primary Care Physician____
Address ____
Phone No. ______________________________ Fax No. _______________________________

How were you referred to our office? ____

Insurance Information

Insured's name if not the same as patient ____
Primary Insurance _________________________________ Secondary Insurance ____________________________
Patients Relationship to insured oSelf oSpouse oChild Other ____________________________________

Preferred Pharmacy ____
Address ____ Phone no. _____________________________

Financing Administration or its intermediate or carriers, or to the billing agent of this physician, any information used in place of the original. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance and other health plans to Paul M. Parker, MD. I understand that I am financially responsible for all charges whether or not paid by said insurance. I have been provided a copy of policy on Advanced Directives and Ownership Disclosures.

Signature____ Date: _________________________