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A Professional Medical Corporation

3704 North Blvd., Suite C
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(318) 443-4576

PATIENT REGISTRATION FORM

Date _____

Name_____ Email _____

Address_____City_____State_____Zip _____

S.S. #_____Home Phone_____ Cell Phone _____

Sex _____ Age _____ Date of Birth _____ Marital Status _____ Spouse _____

Employer _____ Work Phone _____

Address_____City_____State_____Zip _____

Referred By _____ Primary Care Doctor _____

Drug Allergies _____ Pharmacy/Location _____

****Billing: Please complete this section if person responsible for the bill is other than the above patient****

Name_____ Relationship to Patient _____

Address_____City_____State_____Zip _____

S.S. # _____ Home Phone _____Cell Phone _____

Employer _____ Work Phone _____

Address_____City_____State_____Zip _____

Insurance Information

Type of Insurance: ( ) Medicare ( ) Medicaid ( ) Champus ( ) Blue Cross ( ) Workers Comp ( ) Other

Please give us all of your pertinent insurance information. If you have more than one policy we need the information on both carriers.

If your coverage requires a second opinion or pre-admission approval it is your responsibility to inform us.

Primary Insurance _____ Secondary Insurance _____

Address _____ Address _____

Insured Name _____ Insured Name _____

Policy # _____ DOB: _____ Policy # _____ DOB: _____

Contract # _____ Group # _____ Contract # _____ Group # _____

Workers Comp Carrier _____ Do you have an attorney? _____

Address _____ Name _____

Phone _____ Accident Date _____ Address _____ Phone _____

I have received a paper copy or reviewed on the website the clinic's Notice of Privacy Practices and Credit Policy.

_____
Signature