DOCTORS MED CARE

PATIENT REGISTRAION FORM

PLEASE FILL OUT COMPLETELY

Last Name	First		M.I.	Goes by:	
Address		City		State	Zip
Home Phone	Cell Phone	SS#		Driver's License #	
Birth Date	Age	Sex (circle one) M F	Race	Marital Status S M D W	Spouse's Name
Email Address	Patient Employer and Number			Patient Occupation	
In case of emergency notify?		Phone #			
Reason for today's visit:		Is this visit a result of a work injury or car accident? Y N			
Date of injury/accident:		Pharmacy Name/Number:			

RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

Name/First	M.I.	Last		
Address		City	State	Zip
Home Phone	Cell Phone	SS#	Birth Date	
Employer and Phone Number		Occupation		

INSURANCE INFORMATION

Primary Insurance Company		Phone	
Policy Holder's Name:	Birth Date	ID#	Group#
Relationship to Policy Holder: (circle one)	SELF SPOUSE DEPENDENT OTHER		
Secondary Insurance Company		Phone	
Policy Holder's Name:	Birth Date	ID#	Group#
Relationship to Policy Holder: (circle one)	SELF SPOUSE DEPENDENT OTHER		

I hereby authorize Doctors Med Care of Gadsden, P.C. to release any information acquired in the course of my exam or treatment to any person or company that may be liable for all or part of the charges as a result of the treatment. I, the undersigned, authorize and consent to the rendering of medical care, diagnostic procedures, and treatment by Doctors Med Care staff. I acknowledge that no guaranties have been made to the effect of such exams or treatment. When insurance is accepted, the above named patient will be responsible for any unpaid balance after 60 days. Should I fail to pay for the services rendered, I agree to pay the fees from the collection agency and/or attorney, court cost, and any other reasonable cost of collection.

Patient/Legal Guardian Signature:_____ Date: _____