Gregg L Small, M.D.

REGISTRATION FORM

(Please print)

Today's Date: _____Daytime Contact: (Cell #) _____

Referred by: _____Patient's Email Address _____

PATIENT INFORMATION

Patient's Last Name: _____First: _____Middle Initial: _____

Street Address: _____Social Security #: _____

City: _____State: _____Zip Code: _____Home Phone #: _____

Date of Birth: _____Age: _____Marital Status: ____ Single ____ Mar ____Div____Sep____Wid

Occupation: _____Employer: _____

Employer Phone #: _____Other Family Members Seen: _____

INSURANCE INFORMATION (ONLY IF CARD IS NOT PRESENT)

Person responsible for bill: _____Date of Birth: _____

Address (If different): _____

Primary Insurance: _____Subscribers ID #: _____

Group #: _____CoPay: _____Relationship to Subscriber: _____

Secondary Insurance: _____Subscriber ID #: _____

Group #: _____Relationship to Subscriber: _____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): _____

Relationship to Patient: _____Home Phone: _____Work Phone _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance and reasonable costs of collections. Full payment for fees, charges and expenses is due at the time service is rendered. All accounts more than (30) days past due bear interest at the rate of 18% per annum or at the highest legal rate allowed by law.

Patient Signature: _____Date: _____