CONFIDENTIAL PATIENT REGISTRATION

Name: _____ Gender: _____ DOB: ___/___/____
LAST FIRST MI

Address: _____ City: _____ State: _____ Zip: _____

Cell: _____/_____ Home: _____/_____ SS#: _____-____-_____ DL#: _____

Employer: _____ Occupation: _____ Work: _____/_____ x_____

Wk address: _____ City: _____ State: _____ Zip: _____

Marital Status: [ ] single; [ ] married; [ ] partnered; [ ] divorced; [ ] separated; [ ] widow / widower

Spouse: _____ Caretaker: _____ Cell/Office/Home: _____/_____ Referred by: _____

Emergency Contact: _____ Relationship: _____ Cell/Office/Home: _____/_____

PERSON RESPONSIBLE FOR PAYMENT

Name: _____ DL#: _____ Relationship: _____ DOB: ___/___/____

Address: _____ City: _____ State: ___ Zip: _____ H: ___/_____

Employer: _____ Wk address: _____ Work: _____/_____ x_____

INSURANCE INFORMATION

Primary Insurance Co: _____ Group / Plan: _____ Policy ID#: _____

Policy Holder: _____ DOB: ___/___/____ SS#: _____-____-_____

Relationship to patient: _____

Secondary Insurance Co: _____ Group / Plan: _____ Policy ID#: _____

Policy Holder: _____ DOB: ___/___/____ SS#: _____-____-_____

Additional information: _____

_____

CONSENTS

I hereby authorize my physician and any physicians and/or assistants to whom he may designate to render treatment as deemed necessary by my physician. I specifically give **J. Thomas Millington, M.D., Inc**. permission to debride (remove callus and dead tissue with scissors/scalpel & forceps) my wound/s to encourage faster healing.
I hereby authorize **J. Thomas Millington, M.D., Inc**. to release any and all medical information necessary to processes my insurance claims; and, payment of medical and/or surgical benefits directly to **J. Thomas Millington, M.D., Inc.** This authorization shall be valid until revoked in writing. A photocopy of this authorization shall be as valid as an original.
I am aware the office policy is to present my insurance card at each visit and this will be the insurance processed for that date of service. Failure to present my insurance card may jeopardize my benefits and will forfeit any contractual obligation **J. Thomas Millington, M.D., Inc.** may have with my insurance, including retroactive billing and negotiated discounts. I am responsible for knowing my plan benefits as well as any restriction. I understand that I am responsible for any portion of the bill not covered by my insurance and I agree to pay in full at the time of service.
I have read and understand all of the above and hereby state the information is correct to the best of my knowledge.
My signature indicates that I approve and grant request of the authorizations.
In addition,

[OPTIONAL] In addition, I hereby authorize **J. Thomas Millington, M.D., Inc**. permission to document photographically any wound of mine that is treated at this office, and to use such photographs for teaching or other purposes. It is explicit in this authorization that my identity will remain private. [ ] YES [ ] NO Initials: **X**_____ ___/___/_____
DATE

X_____ ___/___/_____ _____
SIGNATURE: PATIENT / LEGAL REPRESENTATIVE DATE IF SIGNED FOR ANOTHER, STATE RELATIONSHIP

(LARGE PRINT EDITION SAMPLE OF CONSENT for reference)

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