PATIENT REGISTRATION

DATE_____

PATIENT FULL NAME_____
LAST FIRST MIDDLE

ADDRESS_____

PRIMARY PHONE_____

CITY_____ STATE_____ ZIP_____ SECONDARY PHONE_____

Your Social Security Number_____ Referring Physician_____

DATE OF BIRTH_____ MARITAL STATUS_____ SEX_____ AGE_____

****

PLEASE CIRCLE THE PROVIDER YOU ARE GOING TO SEE:

ARYAL AVERNENI BALAN COLLINS KIM PHARR

RAMACHANDRAN SYED KENDALL, NP MILLER, PA PREVOST, NP

EMPLOYED BY_____ ADDRESS_____ PHONE_____

Patient's E-Mail Address:_____

Spouse's Name_____ Spouse's Employer_____

Address_____ Phone_____

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I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE

Signed _____ Date_____

I AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENT OF ANY MEDICAL BENEFITS TO THE PROVIDER OF SERVICES, GREENSBORO MEDICAL ASSOCIATES

Signed _____ Date_____

I understand that I am financially responsible for my medical care. My insurance will be filed as a courtesy.