

PATIENT REGISTRATION

Patient Name: _____ Today's Date: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Cell Phone: _____

Email: _____ (for promotional offers/updates only. We will not sell address.)

Date of Birth: _____ Age: _____ Sex: M or F

SSN: _____

Employer: _____ Work Phone: _____

Spouse Employer: _____ Work Phone: _____

Do you wish phone calls to be confidential?: **Yes** **No**
May we contact you at work?: **Yes** **No**

In case of emergency, contact: _____ Relationship: _____

Telephone: _____ Work Phone: _____

Patient referred by: _____ Family Doctor: _____

Doctor Phone: _____

Person Financially Responsible:

Patient _____ Parent _____ Spouse _____ Other _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

I authorize the release of any medical information necessary to process my claim. I authorize payment of medical benefits to James W. Thornton, M.D.

Signed: _____ Date: _____