RANDALL F. HUMPHREYS, M.D.

PATIENT INFORMATION

Please PRINT and FILL OUT COMPLETELY

Patient Name:_____ DOB: ____/_____/_____ AGE_____
LAST FIRST MI

ADDRESS:_____CITY:_____ ST:_____ ZIP:_____

PHONE: HOME: (___)_____ Cell: (___)_____ Work: (___)_____ext_____

SS# _____-_____-_____ MARITAL STATUS: S M W GENDER: M F RACE_____

EMAIL ADDRESS_____

EMPLOYER or SCHOOL: _____OCCUPATION_____

PRIMARY PHYSICIAN: _____ PHONE: **(_____)**_____

REFERRED BY: _____ HOW DID YOU HEAR ABOUT US? Word of Mouth, Phone Book, Internet, Paper, TV, Other

HAVE WE EVER SEEN / ARE WE TREATING ANY OTHER FAMILY MEMBERS IN OUR PRACTICE?

YES_____ NO _____ IF YES, WHO _____

Adults:

EMERGENCY CONTACT NAME_____CONTACT #_____RELATIONSHIP_____

If Child:

GUARDIAN'S NAME_____ SS# _____-_____-_____DOB:____/_____/____

CONTACT #_____WORK#_____RELATIONSHIP TO PATIENT_____

INSURANCE INFORMATION

(Please PRINT and FILL OUT COMPLETELY)

PRIMARY:_____INSURED NAME: _____DOB: _____/_____/_____

SECONDARY:_____ INSURED NAME: _____ DOB: _____/_____/_____

OFFICE POLICY

PLEASE READ AND SIGN BELOW

Payment is due and payable at the time services are rendered. As a courtesy, we will file your insurance for you. Any unmet deductible or co-pay is due at the time of visit.

I agree to be financially responsible for all charges not paid by my insurance. If my insurance fails to pay within 60 days, I understand that I will then be responsible for payment in full. Non payment of claims is between my insurance company and myself. If collection proceedings are required, I also agree to pay for the services rendered, as well as any other fees that may result from these proceedings.

I hereby authorize payment directly to Dr. Randall F. Humphreys for primary and secondary medical benefits, if any, otherwise payable to me for services described. I also authorize the release of medical information necessary to process my insurance claims.

I understand that I must give 24 hours notice if I am unable to keep my scheduled appointments. Otherwise, I agree to accept financial responsibility for time reserved. Missed appointment fee is $25.00.

I further understand that Dr. Humphreys does not admit patients to the hospital. All patients should maintain a primary care physician for urgent care and for your general health care. If you need assistance in finding a primary care doctor, please let us know. I have read the above information and understand these policies.

DATE: ______/______/_______SIGNATURE: ____01/14jt