Registration Form

Dr. Carl E. Thornblade M.D. Date_____

Patient Information:

Patient Name_____Male____Female____ SSN: _____

Mailing Address_____Date of Birth_____Married _____Single_____

City_____State_____Zip Code_____ Age: _____ Home Phone: _____

Cell Phone:_____ Business Phone: _____

Email address:_____

Employer_____Occupation_____ Email: _____

Primary Care Physician: _____

How did you hear about Dr. Thornblade? _____

Insured Information (If not patient) OR Responsible Party for payment:

Insured's Name: _____ Relationship to patient: _____

Mailing Address: _____ Date of Birth_____ SSN: _____

City_____ State_____ Zip Code_____

Home Phone: _____ Cell Phone:_____

Employer_____Business Phone: _____

Mother's Name: Father's Name:

Emergency Information:

Person to Contact for Emergency_____Daytime Phone: _____

Relationship to patient: _____

Insurance Information:

Primary Insurance Company: _____ (Please Present Card for Photo Copy)
Policy #_____
Group #_____

Secondary Insurance Company: _____
Policy #_____
Group#_____

Authorization to Release Information and Assignment of Insurance Benefits

I authorize the release of any medical information necessary to process medical claims. I permit a copy of this authorization to be used in the place of the original. I hereby authorize that payment from my insurance company be made directly to Dr. Thornblade and I understand that I am financially responsible for charges not covered by my insurance company.

_____Date:_____
(Signature of Patient, Policy Holder, or Parent)