

Patient Registration Form

NAME _____
First Middle Last

Address _____ Age _____
Street Apt #

Home Phone _____
City State Zip Area Code Number

Cell Phone _____ Sex Male / Female Marital Status Single / Married / Divorced / Widowed

Social Security Number _____ Date of Birth _____
Month Day Year

Referring Physician? _____

Employer _____
Name City/State Phone number

Spouse/ Parent /Guardian _____ Date of Birth _____
Month Day Year

Spouse/parent/guardian Employer _____
Phone number

Emergency Contact _____
Name Phone number

Name of Policy Holder (if other than patient) _____

Relationship to Policy Holder Self / Spouse / Child Policy Holder date of Birth _____

Policy Holder SS# _____

Payment Policies

All co-pays are due at the time of the visit. If you are unable to do so, please talk to management before seeing the doctor.

I agree to be financially responsible for any and all charges for services rendered by Mark D. Herron, M.D., LLC. I also understand that if payment is not made, that I will be responsible for any attorney fees and/or cost of collection.

Responsible party signature/relationship to patient

By my signature below I acknowledge that I have received the privacy notice of Mark D. Herron, M.D. LLC.

I understand that the physician and staff will not discuss my health information with any family or friends unless I authorize them to do so. I hereby authorize the physician and staff to convey information about my health to the following people.

Relationship _____ Phone # _____

Relationship _____ Phone # _____

Signature of patient or guardian

Date

I give permission to Dr. Mark D. Herron, his employees, and/or agents to contact me at any of the following.

Answering machine Yes/No Home Phone Yes/No

Cell Phone Yes/No Employer Yes/No