Patient Information

Thank you for choosing our office! In order to serve you properly, we need the following information.
Please print. All information will be confidential.

Patient Name Last	First	MI	Date of Birth	Age	Chart #

Street Address	☐ Male ☐ Female

City	State	Zip Code	Email Address ☐ send me emails about special offers

Social Security Number	Driver's License Number

Home Phone ☐ Primary	Work Phone ☐ Primary	Cell Phone ☐ Primary

Referred By:	

Insurance Information

(Please present your Driver's License and Insurance Cards to the Receptionist)

Name of Insured	Date of Birth	Relationship to Patient	
Primary Insurance Company	**ID Number**	**Secondary Insurance Company**	**ID Number**

In Case of an Emergency

Contact	Phone	Relationship

Primary Care MD	Primary Care Phone Number

Patient Authorization of Disclosures

I wish to be contacted in the following manner: (check all that apply)

Home Phone	**Cell Phone**
☐ Ok to leave message with detailed information	☐ Ok to leave message with detailed information
☐ Leave message with call-back number only	☐ Leave message with call-back number only
☐ Do not call	☐ Do not call
Work Phone	**Written Communications**
☐ Ok to leave message with detailed information	☐ Ok to mail to my home
☐ Leave message with call-back number only	☐ Ok to email me
☐ Do not call	

Release of Medical Information and Assignment of Benefits

I hereby authorize John B. Harris, MD, PA to release information regarding my treatment or examination rendered to me for medical or surgical care to my insurance company(s) or its representatives. I also authorize payment to be made directly to John B. Harris, MD, PA in the amount due for all medical and /or surgical charges for myself or eligible dependents. I understand that I am financially responsible for any amount not covered or paid by my insurance company (s). Furthermore, I authorize John B. Harris, MD, PA to obtain my medical records from any necessary hospital, clinic or doctor's office.

Signature _____ Date _____