PATIENT INFORMATION

(PLEASE PRINT)

PATIENT:_____CALLED NAME:_____SEX: M or F
First Middle Last (Circle)

MAILING ADDRESS:_____/_____/_____/_____
(Road, Street, P.O. Box #) (Town) (Zip) (County)

PLACE OF WORK:_____SCHOOL: (if minor):_____GRADE:_____

DATE OF BIRTH:_____HOME #:_____WORK #:_____CELL #:_____

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RESPONSIBLE PERSON INFORMATION

(Fill out only if patient is a minor)

MOTHER:_____HOME #:_____WORK #:_____CELL #:_____

MAILING ADDRESS (if different from patient):_____

FATHER:_____HOME #:_____WORK #:_____CELL #:_____

MAILING ADDRESS (if different from patient):_____

WHO HAS LEGAL CUSTODY OF THE CHILD?_____

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INSURANCE INFORMATION

_____	_____
(Primary Insurance Company)	**(Secondary Insurance Company)**
_____/_____	_____/_____
(Policy Holder's Name) (DOB)	**(Policy Holder's Name) (DOB)**
_____/_____	_____/_____
(Subscriber #) (Social Security #)	**(Subscriber #) (Social Security #)**
_____	_____
(Group Number)	**(Group Number)**
CLAIMS MAILING ADDRESS:	CLAIMS MAILING ADDRESS:
_____	_____
_____	_____
_____	_____

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I authorize the evaluation and/or treatment of the patient identified above and agree to pay all charges for the evaluation and/or treatment provided. I hereby authorize the release of information related to the services provided to my insurance and/or managed care company and authorize payment by the insurance and/or managed care company directly to Dr. Robert D. Gregory. A copy of this authorization can be used in place of the original.

SIGNATURE:_____***DATE:***_____
(Responsible Person)