Melissa Morgan, M.D., P.C.
Patient Registration Form

Today's Date ____/____/_____

PATIENT INFORMATION *(Please Print)*

Name _____ SS# _____
Last First M.I. Social Security Number

Mailing Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth ____/____/_____ Age_____ Sex _____ Marital Status _____ Drivers License # _____

PARENT OR RESPONSIBLE PARTY *(If different from patient)*

Name _____
Last First M.I.

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth ____/____/_____ Sex _____

INSURANCE INFORMATION ***(Please present insurance card at time of check in.)***

Primary Insurance Name _____
Ins. Address _____
Name of Insured _____
Insured's Date of Birth _____
Insured's ID# _____
Group # _____
Employer Name _____
Relationship of patient to the Insured _____

Secondary Insurance Name _____
Ins. Address _____
Name of Insured _____
Insured's Date of Birth _____
Insured's ID# _____
Group # _____
Employer Name _____
Relationship of patient to the Insured _____

Other family members that are patients _____
Pharmacy of choice _____ Phone # _____
In case of Emergency, who should be notified? _____
Who referred you to our practice? _____
Primary Care Physician _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Date _____/_____/_____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. **APPLICABLE CO-PAYMENTS AND DEDUCTIBLES WILL BE COLLECTED.** We accept payment in the form of cash, check, or credit card (VISA or MasterCard). If we are filing insurance, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account. Insufficient check charges are $25.00. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _____ Date _____/_____/_____