

JAMES E. CHAPPELL, MD PA

PATIENT DEMOGRAPHIC INFORMATION

PATIENT REGISTRATION

Patient Name: _____ Age: _____ Date of Birth: _____ Sex: _____
Address: _____ SS#: _____
City: _____ Home Telephone: _____
County: _____ State: _____ Zip: _____ Cell phone: _____
Driver's License Number: _____ Email: _____
Referred By: _____ Marital Status **S** **M** **W** **D** **Sep**
Emergency Contact (i.e. friend/spouse): _____ Relationship: _____
Employer/Address of Above Person: _____ Phone No: _____

PATIENT EMPLOYER INFORMATION

Employer Name: _____ Work No: _____
Employer Address: _____
Patient's Occupation: _____

INSURANCE INFORMATION

Primary Insurance Company Name: _____
Subscriber Name: _____
Subscriber Date of Birth: _____ **Subscriber employer:** _____
Policy No.: _____ Group No.: _____
Secondary Insurance Company Name: _____
Subscriber Name: _____
Subscriber Date of Birth: _____ **Subscriber employer:** _____
Policy No.: _____ Group No.: _____
Party Responsible for payment of Bill: _____

INJURY INFORMATION

N/A **Date of Injury** _____ **Is Injury Work Related?** _____
Was Emergency Care Given? **Yes** **No** If yes, where? _____
Were X-Rays Taken? **Yes** **No** If yes, where? _____
Insurance Company/Agent: _____ Phone No.: _____
Name of Attorney: _____ Phone No.: _____
Was an Automobile Involved in the Injury? _____
PIP Carrier(If different from above): _____ Phone No.: _____
Address: _____

All co-payments/deductibles are due at the time of service. If surgery is indicated, the patient is responsible for furnishing the proper referral forms to the office prior to surgery. All professional services rendered are charged to the patient. The necessary forms will be completed to expedite insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. Fees for special medical reports to attorneys vary with the complexity of the report and are payable in advance.

I hereby authorize James E. Chappell, MD, PA to furnish to my insurance carrier/ attorney concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependent. **I understand that I am responsible for any amount not covered by insurance.**

SIGNATURE: _____

DATE: _____