WILLIAM C. MAJOR, M.D. – Patient Information Sheet

Date __________ How Did You Learn About Dr. Major? ( ) Primary Care Referral ( ) Internet Ad ( ) Family/Friend

( ) Other ____________ Name of your Family Doctor ______________________

Patient's Full Name ______________________________ Age _____ Sex _____ Birthdate ____________

Address ____ City ___________ State _____ Zip ________

Social Security # ___________________ Home Phone # ___________________ Cell Phone # _____________

Patient's Employer _______________________________ ____________________________

Spouse's Name ___________________________________ Social Security # _________________________

Spouse's Employer ________________________________ Spouses's Cell # _________________________

Friend/ Relative at different address ______________________________ Phone # _____________________

Email Address: ____

TO BE COMPLETED ONLY IF PATIENT IS A MINOR
MINORS WILL BE TREATED ONLY WHEN ACCOMPANIED BY PARENT OR GUARDIAN

Father's Name __________________________________ Address __________________________________

Social Security # _________________________________ Home Phone # ____________________________

Father's Employer ________________________________ Work Phone # ____________________________

Mother's Name __________________________________ Address __________________________________

Social Security # _________________________________ Home Phone # ____________________________

Mother's Employer ________________________________ Work Phone # ____________________________

SIGNATURE OF PARENT/GUARDIAN TO TREAT MINOR ___________________________ DATE _______

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Dr. William C. Major to furnish information to insurance carriers and other doctors concerning my illness and treatments. I hereby assign to the physician or supplier all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

WE REQUEST OFFICE VISITS TO BE PAID AT THE TIME SERVICES ARE RENDERED.

INSURANCE INFORMATION—Please let us make copies of your insurance cards for our files.

BY SIGNING THIS FORM, I GIVE DR. WILLIAM C. MAJOR PERMISSION TO PROVIDE TREATMENT.

SIGNATURE X ____ Date __________________________