Mody & Miller M.D., P.A.

Patient Registration

Please print in black ink and answer all questions in full **Date:** _____

Patient Information (please complete using your name as listed on your insurance card)

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address: _____

Date of birth: _____ **SS#** _____

Marital Status: Single _____ **Married** _____ **Divorced** _____ **Widow** _____ **Sex: M** _____ **F** _____

Occupation: _____ **Employer:** _____

Pharmacy Name: _____

Address: _____ **Phone #** _____

Referring Physician: _____ **Phone #** _____

Primary Care Physician: _____ **Phone #** _____

Insurance Information

All patients must provide a copy of their insurance card and drivers license at the time of their visits.

Primary Insurance: _____ Name of Policy Holder: _____ Relationship: _____

Policy Holder DOB: _____ Policy #: _____ Group #: _____

Secondary Insurance: _____ Name of Policy Holder: _____ Relationship: _____

Policy Holder DOB: _____ Policy #: _____ Group #: _____

Where may we contact you and/or leave messages regarding diagnosis, treatment plan, and/or test results?

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Emergency Contact Information

Name: _____ **Relationship:** _____ **Phone:** _____

Patient Release

Must be signed by patient if over 18 or by legal guardian of patient under 18.

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits of the provider.

Signature: _____ Today's Date: _____