Date_____

Dr. Susan M. Morrison
Registration Form

Patient Information (Please Print Clearly)

Legal Name_____
Last name First name Middle Initial "nickname" if applicable

Address_____ City_____ State_____ Zip_____

Home #_____ Work#_____ Cell#_____

Birth Date_____ Age_____ SS#_____ ☐Single ☐Married ☐Domestic Partner ☐Widowed ☐ Divorce

Employer_____ Occupation _____

Business Address_____ City_____ State_____ Zip_____

Whom may we thank for referring you?_____

Primary Care Physician/Internist_____ Phone#_____

Incase of emergency that should be notified?_____ Phone#_____

Primary Insurance Information

Insurance Company_____ Insurance phone #_____

Subscribers/Member ID#_____ Group#_____

Subscribers Name/Insured_____

Relation to Patient_____ Birth Date_____ SS#_____

Address (if different from patients)_____ City_____ State_____ Zip_____

Additional Insurance Information

Is patient covered by additional Insurance? ☐ Yes ☐ No

Insurance Company_____ Insurance phone #_____

Subscribers/Member ID#_____ Group#_____

Subscribers Name/Insured_____

Relation to Patient_____ Birth Date_____ SS#_____

Address (if different from patients)_____ City_____ State_____ Zip_____

Assignment and Release I understand that I will receive a separate bill from an independent laboratory for any laboratory analysis, i.e. blood work, biopsies, cultures and pap smears. I also understand that I am responsible to pay the laboratory for their services. I understand that if I have services and/or procedures, wither at the hospital, or a surgery center, that there will be a separate bill from the facility for which I will be financially responsible. I undersigned, assign directly to Dr. Susan M. Morrison all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not I have insurance along with any late fees that may apply for unpaid balances. I hereby authorize to the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible party signature Relationship Date