

Dr. Susan M. Morrison
Registration Form

Date _____

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, whether 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