WILLIAM P. BAUGH, M.D., INC.
PATIENT REGISTRATION RECORD

Date _____

Patient Name _____
First Name Middle Initial Last Name

Mr./Mrs./Ms./Miss Married/Single **Spouse's Name** _____
Circle One Circle One

SS# _____ **Date of Birth** _____ **Age** _____

Race Asian Black Caucasian Hispanic Native American Other
Circle One

Home Phone _____ **Cell Phone** _____

Address _____
Street City Zip

Parent Name _____
if pt is a minor

Email Address _____
We occasionally send out updates and information via email. Would you like to be included in receiving these emails? **YES** or **NO**
Circle One

Employer _____ **Phone** _____

Employer Address _____

Insurance Co _____ **Subscriber** _____ **DOB** _____

Secondary Insurance _____ **Subscriber** _____ **DOB** _____

Family Physician _____ **Pharmacy** _____
(name/location)

How Did You Hear of Us? _____

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize William P. Baugh, M.D. Inc. to furnish information to insurance companies concerning this illness and I hereby irrevocably assign to my physician all payments for services rendered. I understand that I am responsible for any balance I understand that I am responsible for any balance not paid by my insurance company.

_____
Signature of Patient or Parent