Judith L. Thompson, M.D., P.A.

PATIENT REGISTRATION FORM

Section 1 (Please Print)

REFERRING DOCTOR:	PRIMARY CARE DOCTOR:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status: Single/ Mar/ Div/ Sep/ Widow(er)

Home Phone	Cell Phone	Work Phone	Age:	Sex: ❑ M ❑ F

Physical Address:

City:	State:	Zip:	Birthdate:	Social Security Number:

Mailing Address:	City:	State:	Zip Code:

Occupation:	Employer:	Employer Phone Number:

Preferred Pharmacy:	Phone number:

Section 2 PRIMARY INSURANCE INFORMATION

(If primary insured is different from patient please complete section 2)

Person responsible for bill:			Mailing Address:	
Home Phone:	Cell Phone:		Birthdate:	
Is this person a patient here? ❑ Yes ❑ No	Occupation:		Employer:	
Employer Address:			Employer Phone Number:	

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Medicare	❑ Medicaid	❑ BCBS	❑ Other

Subscriber's Name:	Birthdate:	Subscriber's Social Security Number:

Group Number:	Policy Number:			
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Section 3 SECONDARY INSURANCE

Name of Secondary Insurance (if applicable):	Subscriber's Name:	Birthdate:
Group Number:	Policy Number:	Subscriber's Social Security Number:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative: (not living at same address)	Home Phone:	Cell Phone:
May We Release Information To This Person?	Relationship to patient:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature **Date:**