

**Terry Allen MD & Scott Forrest MD, PLLC
PATIENT REGISTRATION FORM**

Name (Last, First Middle/Maiden)		
Address:		
City:	State:	Zip Code:
Phone, Home: ()	Work: ()	Mobile: ()
Email:		
Date of Birth:	SS Number:	
Marital Status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed		
Employer:	Phone: ()	
Address:		
City:	State:	Zip Code:
Spouses Name (Last, First Middle):		
Phone, Home ()	Work: ()	Mobile: ()
Emergency Contact (if not spouse):		Relationship:
Phone, Home: ()	Work: ()	Mobile: ()

Primary Insurance Company:		
Type of Insurance: <input type="radio"/> HMO <input type="radio"/> PPO <input type="radio"/> EPO <input type="radio"/> Indemnity		
Subscriber Name: (Last, First Middle):		
ID Number:	Group Number:	
Relationship to Insured: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other _____		
Office Visit Co-payment: \$	Yearly Deductible: \$	
IF NOT SELF PLEASE PROVIDE THE FOLLOWING INFORMATION OF THE SUBSCRIBER:		
Date of Birth:	SS Number:	
Address:		
City:	State:	Zip Code:
Phone, Home: ()	Work: ()	Mobile: ()
Employer:	Phone: ()	
FOR OBSTETRICAL PATIENTS ONLY:		
Does your insurance policy provide obstetrical coverage? <input type="radio"/> Yes <input type="radio"/> No		
Do you have a deductible? <input type="radio"/> No <input type="radio"/> Yes (Is this a percentage or up to a certain amount?) _____		
Do you have a co-payment? <input type="radio"/> No <input type="radio"/> Yes \$ _____ (Do you pay this once or each visit?) _____		

Release of Medical Information: Please list any individuals we may release medical information to:	
O None: only release medical information to me	
Name: _____	Relation: _____
Name: _____	Relation: _____
Name: _____	Relation: _____

Patient Signature: _____	Date: _____
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