PATIENT REGISTRATION FORM
ROSALINDA TAYMOR, M.D.

PATIENT INFORMATION

Name (First, M.I., Last):_____

Address (Street/Apt/Box):_____

(City, State, Zip):_____

Phone (H):_____ (C):_____ (W):_____

Birthday: _____ Gender: M____ F_____ Marital Status: _____

Social Security # _____ Employer: _____

INSURANCE INFORMATION

PRIMARY INSURANCE
Insured ID #: _____
Policy/Plan/Group #:_____Copay: _____
Policyholder Name: (Frist, M.I., Last) _____
Date of Birth _____ Relationship: _____

Pre-Authorization required for visit? Yes _____ No _____
Authorization Number: _____
Number of Visits Authorized: _____
Dates Valid: _____
Primary Care Physician Name: _____

AUTHORIZATION OF BENEFITS:

I hereby authorize the practitioner whose name appears above to furnish my insurance company all information which the insurance company may request concerning my present illness or injury. I hereby assign to the practitioner whose name appears all money to which I am entitle for medical expense relative to the service reported above but not to exceed my indebtedness to said practitioner. I understand that I am financially responsible to said practitioner for charges not covered by my insurance company.

_____ _____
Patient Signature Date