# William H. Brown, III, M.D.
## Registration Information

Patient's Name: _____
LAST NAME FIRST NAME MIDDLE INITIAL

Street Address: _____

City: _____

State, Zip: _____Home Phone: _____

Date of Birth: _____Age:_____

Sex: M F

Marital Status: Single Married Separated Divorced Widowed

Social Security No.: _____ Email _____

Occupation:_____
Employer: _____Work Phone: _____
Employer's Address: _____

Spouse's Name (Or Parent's, if patient is child or if spouse is subscriber)
_____
Date of Birth:_____
Address, if different than above: _____
Home Phone: _____
Employer: _____Work Phone: _____
Social Security No.:_____

Current Medications: _____
_____

Medical Allergies:_____

Referred by: _____Relationship:_____

Reason for visit: _____

Primary Insurance: _____Copay Amount_____
Secondary Insurance: _____

Emergency Person (at different phone): _____Relationship_____
Emergency Phone No.: _____

I authorize my insurance company to pay to William H. Brown M.D., all benefits to which I am entitled for the services provided by William H. Brown M.D. This assignment is in effect until revoked in writing. I also authorize the release of any information necessary to secure payment. I understand that I am responsible for the costs if the insurance company does not pay.

Signature:_____ Date:_____