Welcome to our office
Thank you for completing this form

Required Patient Information

Patient Name_____ Soc. Sec #_____
Last First MI

Address _____

City _____ State _____ Zip _____

Age_____ Date of Birth_____ Sex _____ Marital status: s ☐ m ☐ d ☐ w ☐ dp ☐

Height: _____ Weight: _____ Date: _____ _____

Home phone_____ Cell phone _____

Work phone_____ Best # to reach you _____

Email _____

Pharmacy: _____City:_____

May this email be used to notify you of news, updates or specials? Yes ☐ No ☐

Employer_____ Occupation _____

Name of parent if patient under 18 _____

Emergency contact _____
Name Relation to patient phone

Referred by _____
If newspaper, yellow pages, friend please be specific

Primary Care Physician _____

Insurance Information

Medicare number _____

Primary Insurance_____ ID/group# _____

Subscriber name _____Date of birth _____

Secondary insurance _____ ID/group #_____ Co-pay_____

Financial Assignment and Agreement

I hereby give indefinite authorization for payment of insurance to be made directly to Paul T. Stallman, MD, Inc. for services provided. I understand that I am financially responsible for all charges whether or not paid by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize the release of all information necessary to secure the payment of benefits. I understand that failure to provide this office with current insurance information may result in my being responsible for all charges.

Signature of responsible party _____ Date _____