

Thomas R Traylor, MD and Michael Fields, MD

PATIENT INFORMATION

Date _____ Chart # _____
Patient Name: (Last) _____ (First) _____ (MI) _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ 2nd # _____ Indicate ____ Cell ____ Other ____
Date of Birth _____ SS# _____ Marital Status _____
Employer _____ Ph # _____

Husband or Parent's Information:

Name _____ DOB _____ SS# _____
Spouse or Parent's Employer _____ Ph# _____

INSURANCE INFORMATION

Primary Insurance Co. _____
Insured Name _____
If Insured Person is different from you or spouse, Date of Birth _____ SS# _____
Secondary Insurance Co. _____
Insured Name _____
If Insured Person is different from you or spouse, Date of Birth _____ SS# _____
Nearest Relative Not living with you: _____ Phone _____
In case of emergency contact: _____ Phone _____

If someone other than the patient is responsible for account, please give us the name and mailing address:

*****PLEASE BRING ALL INSURANCE CARDS AND YOUR DRIVER'S LICENSE TO THE RECEPTIONIST SO WE MAY SCAN THEM AND PLACE THEM IN YOUR FILE-----REQUIRED BY INSURANCE CARRIERS***

Thank you for your patience while we complete your information.