Patient Registration www.thestorkmd.com

Date _____ SSN_____-_____-_____ Driver's License#_____

Last Name_____ First Name_____ MI _____

Address_____ City, State, Zip Code_____

How long at present address: _____ e-mail_____
Ok to contact me via e-mail: Y N

Home Phone_____ Cell Phone_____
(include area code) (include area code)

Date Of Birth_____ Marital Status: S M D W Referring MD_____

Employer _____ Work Phone _____
(include area code)

Work Address_____Occupation_____
(include city and zip)

Spouse's Name_____ Work Phone_____SS# ____-____-_____ DOB_____
(include area code)

Nearest relative _____ Phone_____ Relationship_____
(not living w/you)

Whom may we thank for referring you? _____ Phone_____

In case of emergency _____Phone_____ Drug Allergies: Y N
(not nearest relative as stated above) **Specify_____**

Pharmacy for Prescriptions _____

Primary/Family Physician _____

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Primary Insurance
(please complete if you are not the policy holder)

Policy Holder_____

SSN_____ DOB_____

Employer _____

Relationship to insured __Spouse __Child __ Other

Secondary Insurance
(please complete if you are not the policy holder)

Policy Holder_____

SSN_____ DOB_____

Employer _____

Relationship to insured __Spouse __Child __ Other

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Responsible Party Information: (if under 18 years of age, please complete this section)

SSN_____-____-_____ Last Name _____ First Name _____ MI ___

Address _____ City, State ZipCode _____

Home Phone _____ Date of Birth_____ Sex: F M

Employer _____ Work Address _____ City Zip Code_____

Work Phone_____ Relationship to patient _____

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Demographic Information Verified with No Changes: _____/_____/_____/_____/_____
(For Office Use Only) **Date Date Date Date Date**

Bradley D. Campbell, M.D., FACOG Disclosure/Agreement

Date: _____ **Patient Name:** _____

A note from Dr. Campbell - I realize that your time is very important and that traditionally patients wait too long to be seen. I strive to be on time for your scheduled appointment: I do not overbook/double book patient appointments. However, sometimes a patient will go into labor or an emergency arises. My staff will inform you immediately of these situations thereby minimizing any inconvenience this may cause you.

Reason for Today's Visit:

[ ] Routine Preventative Exam (I have no medical complaint or significant problem or abnormality of which I am aware)
[ ] I have a problem/complaint that I wish evaluated/treated by the doctor. My chief complaint is _____
_____

[ ] My insurance plan covers Preventative Services [ ] My insurance plan does not cover Preventative Services
[ ] I do not know if my insurance plan covers Preventative Medical Services

If I do not receive test results seven days after rendered services I will call the office to obtain these results. I also understand I am to call the office during normal business hours unless it is an emergency. Office hours are M, T, TH 8am – 5pm and W, F 8am – 12noon.

I agree to pay for any and all medical services I receive from the doctor/providers of this practice (including co-payments) that my insurance company refuses to pay. This office will file a claim at no charge on my behalf. If my insurance company denies payment for any reason (e.g. non-covered services, no routine coverage) I will pay for services rendered. Failure to pay within 45 days of filing is, for the purpose of this agreement, a refusal to pay. Failure to make payment prior to my next visit will result in appointment cancellation. I also understand that failure to cancel my appointment **within 24 hours** or more than two occasions or failure to show on more than two occasions may result in discharge from the practice. Furthermore, if I am tardy for my appointment, I may be asked to reschedule for another time.

I understand that I am responsible for presenting my insurance identification card upon each visit to this office. This helps ensure that all appropriate information about me is on file and accurate. I also hereby authorize my insurance benefits to be paid directly to the physician and authorize the release of any medical information necessary to process this claim.

I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical record. Thus, to ask this office to change a diagnosis for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.

In the event I do not pay for services provided me when due, I agree to pay all cost of collection, including reasonable attorney fees, whether or not a law suit is commenced as part of the collection process.

Patient Signature _____ **Witness** _____

Please complete and sign if insured under MEDICARE:

I certify that the information given by me applying for payment under the title XVIII of the Social Security Act is correct. I authorize any holder of medical or information about me to release to the Health Care Financing Administration or its intermediaries or carries any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Patient Signature _____ **Witness** _____