

**CHARLOTTE B. ALEXANDER, MD
PATIENT REGISTRATION**

DATE: _____

NEW PATIENT: _____
UPDATE: _____

PLEASE COMPLETE ENTIRE FORM PATIENT INFORMATION

NAME: _____
(LAST NAME) (FIRST NAME) (INITIAL)

ADDRESS: _____
(NUMBER) (STREET) (APT) (CITY) (STATE) (ZIP)

DOB: _____ AGE: _____ MALE FEMALE MARITAL STATUS: _____ HOME PHONE: (____) _____

SOCIAL SECURITY #: _____ DRIVER'S LICENSE #: _____ CELL # (____) _____

EMPLOYER: _____ OCCUPATION: _____ WK PHONE: (____) _____

REFERRED TO THIS OFFICE BY: _____ PHONE: (____) _____
(IF PHYSICIAN PLEASE PRINT PHYSICIAN'S FULL NAME)

INSURANCE INFORMATION

*** PLEASE COMPLETE THE INFORMATION BELOW SO WE MAY FILE YOUR INSURANCE CLAIM ***

PRIMARY INSURANCE: _____

INSURED PERSON: _____ DOB: _____ SSN: _____

EMPLOYER NAME: _____ BUSINESS PHONE: (____) _____

EMPLOYER BUSINESS ADDRESS: _____

SECONDARY INSURANCE: _____

INSURED PERSON: _____ DOB: _____ SSN: _____

EMPLOYER NAME: _____ BUSINESS PHONE: (____) _____

EMPLOYER BUSINESS ADDRESS: _____

GUARANTOR INFORMATION (if different from Patient)

SPOUSE PARENT GUARDIAN NAME: _____

EMPLOYER: _____ PHONE: (____) _____

BUSINESS ADDRESS: _____ CELL # (____) _____

MEDICAL HISTORY (Please answer Yes or No)

ON-THE-JOB INJURY: YES NO IF YES, DATE OF ACCIDENT: _____ DATE LAST WORKED: _____

MOTOR VEHICLE ACCIDENT: YES NO IF YES, DATE OF ACCIDENT: _____

TREATED BY ANOTHER DR. FOR THIS PROBLEM? YES NO IF YES, WHERE OR WHO: _____

IN CASE OF EMERGENCY

PLEASE LIST SOMEONE OTHER THAN PERSONS LIVING AT YOUR RESIDENCE

NAME: _____ RELATIONSHIP: _____ PHONE: (____) _____

ADDRESS: _____
(CITY) (STATE) (ZIP)

ASSIGNMENT AND RELEASE

This signature will authorize Charlotte B. Alexander, M.D. Tax ID 86-1079811 to provide the indicated Medical/Surgical care necessary for my treatment. Should it be necessary, I hereby authorize my insurance to pay directly to Charlotte Alexander, MD all benefits otherwise payable to me under the provisions of this policy. I also authorize the release of all medical information to the insurance company that is required to process all claims. I understand this authorization may be mailed or faxed to my insurance company.

Signature of Insured: _____ Date: _____

Signature of Patient (or parent): _____ Date: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any amount consistent with the contract or limits defined within your insurance plan.**

IN ORDER TO CONTROL COSTS OF BILLING, WE REQUEST THAT CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.