

DOUGLAS C. MC CORKLE, M.D.  
PATIENT INFORMATION

PLEASE PRINT CLEARLY . . .

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_  
ZIP CODE \_\_\_\_\_ STATE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_  
MALE \_\_\_\_ FEMALE \_\_\_\_ MAIDEN NAME \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_/\_\_\_\_/\_\_\_\_  
HOME PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_ EXT \_\_\_\_ STUDENT? F/T \_\_\_\_ P/T \_\_\_\_  
PAGER ( ) \_\_\_\_\_ - \_\_\_\_\_ CELL PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_  
MARITAL STATUS (CIRCLE ONE): SINGLE MARRIED DIVORCED WIDOWED SEPARATED  
EMPLOYER \_\_\_\_\_ FULL TIME \_\_\_\_ PART TIME \_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP \_\_\_\_\_  
FAMILY PHYSICIAN / PEDIATRICIAN \_\_\_\_\_ OFFICE PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_

RESPONSIBLE PARTY: (COMPLETE ONLY IF PATIENT IS A DEPENDENT)

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_  
ADDRESS \_\_\_\_\_ HOME PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ FULL TIME \_\_\_\_ PART TIME \_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP \_\_\_\_\_

INSURANCE INFORMATION:

INSURANCE COMPANY NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_  
SUBSCRIBER'S LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_  
SUBSCRIBER'S SOCIAL SECURITY # \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_  
INSURANCE NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ FULL TIME \_\_\_\_ PART TIME \_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP \_\_\_\_\_

SECONDARY INSURANCE COMPANY NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_  
SUBSCRIBER'S LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_  
SUBSCRIBER'S SOCIAL SECURITY # \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_  
INSURANCE NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ FULL TIME \_\_\_\_ PART TIME \_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_ ZIP \_\_\_\_\_

IS YOUR PROBLEM DUE TO AN ACCIDENT? \_\_\_\_\_ YES \_\_\_\_\_ NO DATE OF ACCIDENT \_\_\_\_\_

AUTO ACCIDENT? \_\_\_\_\_ YES \_\_\_\_\_ NO OTHER \_\_\_\_\_

ATTORNEY NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE NUMBER ( ) \_\_\_\_\_ - \_\_\_\_\_ FAX NUMBER ( ) \_\_\_\_\_ - \_\_\_\_\_

NAME OF PHYSICIAN WHO REFERRED YOU TO THIS OFFICE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE #: \_\_\_\_\_

### INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Douglas C. McCorkle, M.D. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Dr. McCorkle all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance. In addition, I understand that I am responsible for informing Dr. McCorkle's office of any changes to my insurance coverage. I understand that by failing to inform Dr. McCorkle's office of any changes that I am financially responsible for all services provided to me or my dependants. I understand I am responsible for this account. In the event my account is turned over to a third party due to default, I am responsible for all collection and attorney's fees as well as all court cost.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_