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 _____