PHARMACY____________________

ALLERGIES____________________

____MARTIN E. HANISCH, M.D., P.A.
____N. CHRISTOPHER BREHM, M.D., P.A.
____ALEXANDER J. ASHMORE, M.D.
____GORDON R. WELCH, JR., M.D., P.A.
____ROBERT A. MAY, JR., M.D., P.A.
____ALAN A. NISBET, M.D.
____JAMES B. TYREE, M.D., P.A.
____ROBERT A. NAISMITH, M.D., P.A.

PLEASE BE SURE ALL INFORMATION IS COMPLETE PATIENT#:________ MR#:__________

LAST NAME:____________________ FIRST:____________________ MI:_____ NICKNAME:__________

SS#:____________________ DATE OF BIRTH:____/____/____ SEX: MALE or FEMALE

ADDRESS:____________________ CITY:____________________ STATE:______ ZIP:__________

SECONDARY ADDRESS:____________________ CITY:____________________ STATE:______ ZIP:__________

RACE:________ LANGUAGE:__________ RELIGION/CHURCH:__________ PRIMARY CARE PHYSICIAN:__________

MARITAL STATUS:__________ ☐ STUDENT - FULL TIME / PART TIME ☐ VETERAN ☐ SMOKER

HOME PHONE:__________ DAY PHONE:__________ CELL PHONE:__________ ALT. PHONE:__________

CONTACT PREFERENCE:__________ EMAIL ADDRESS:__________ REFERRING PHYSICIAN:__________

EMPLOYER:__________ EMPLOYER ADDRESS:____________________ EMPLOYER PHONE:__________ EXT.______

OCCUPATION:__________ EMPLOYMENT STATUS: FULL TIME / PART TIME / SELF / RETIRED RETIREMENT DATE:__________

SPOUSE'S NAME:____________________ DATE OF BIRTH:____/____/____ SS#:__________

EMPLOYER:__________ EMPLOYER ADDRESS:____________________ EMPLOYER PHONE:__________ EXT.______

OCCUPATION:__________ EMPLOYMENT STATUS: FULL TIME / PART TIME / SELF / RETIRED RETIREMENT DATE:__________

EMERGENCY CONTACT NAME:__________ ADDRESS:__________ PHONE:__________ RELATIONSHIP:__________

INSURANCE—IF WE HAVE COPIED YOUR INSURANCE CARD, YOU MAY LEAVE THIS PORTION BLANK

MEDICARE NUMBER:____________________ MEDICAID NUMBER:____________________

PRIMARY INSURANCE:__________ POLICY HOLDER:__________ RELATIONSHIP:__________

POLICY#:__________ GROUP#:__________ INSURANCE ADDRESS:__________ PHONE:__________

SECONDARY INSURANCE: __________ POLICY HOLDER:__________ RELATIONSHIP:__________

POLICY#:__________ GROUP#:__________ INSURANCE ADDRESS:__________ PHONE:__________

ASSIGNMENT OF INSURANCE: I hereby authorize payment directly to the above named physician for the Surgical and/or Medical Benefits, if any, otherwise payable to me for his service. I understand I am financially responsible for charges not covered by this assignment.
AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION: I hereby authorize the above named physician to obtain any medical information or records which will aid in the treatment or diagnosis of my illness. I also authorize the above named physician to release any information acquired in the course of my examination or treatment to other physicians or to insurance companies.

PLEASE CIRCLE METHOD OF PAYMENT FOR TODAYS VISIT: CHECK CASH CREDIT CARD OTHER:__________

PATIENT'S SIGNATURE:____ **DATE:**__________