CLINTON WEBSTER, M.D.
PATIENT REGISTRATION

Please fill out completely.

Patient Name _____ **SS Number** _____/_____/_____
(Last) (First) (MI)
Birthdate _____/_____/_____ **Age** _____ **Male** □ **Female** □ **Marital Status** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone Number (_____) _____ **Cell Phone Number** (_____) _____

E-Mail Address _____ **Referred By** _____

Check here if you would not like to receive notification about specials and events □

EMPLOYMENT INFORMATION ***(If the patient is a minor child please provide parents information.)***

Employer _____ **Position/Department** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Phone Number with Extension (_____) _____

RESPONSIBLE PARTY INFORMATION ***(Please provide if the patient is NOT the responsible party.)***

Name _____ **Relationship** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone Number (_____) _____ **Cell Phone Number** (_____) _____

SPOUSE INFORMATION

Name _____ **SS Number** _____/_____/_____

Cell Phone Number (_____) _____

Employer _____ **Position/Department** _____

Phone Number with Extension (_____) _____

Please provide the name and address of a relative or friend who may be contacted.

Name _____ **Relationship** _____

Home Phone Number (_____) _____ **Cell Phone Number** (_____) _____

INSURANCE INFORMATION ***(The receptionist will copy your insurance card(s) if you have one.)***

Name of Insurance Company _____

Member Name _____ **ID Number** _____ **Group Number** _____

Address, City, State, & Zip Code _____

AUTHORIZATIONS

I hereby authorize that pre and post-operative photographs be taken of me for medical records, teaching, and/or publications, etc. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plans to: CLINTON WEBSTER, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as a valid original. I understand that I am responsible for any and all charges whether or not paid by my insurance company. I hereby authorize Dr. Webster to release all information necessary to secure the payment.

Patient Signature _____ **Date** _____