Registration Form

PATIENT:

circle one : married divorced widowed single

Name:_____ **Spouse**_____
Last First Initial Name

Address:_____
Street City State Zip

Birthdate:_____**Age:**_____**Sex: Male Female**

Home Phone:_____ **Work** _____ **Cell**_____

Email Address: _____Appointment Confirmation Preference: Call Email TXT

Social Security Number:_____**Full Time Student Yes No**
Part Time Student Yes No

PATIENTS: **(Employment Status) Full Time – Part Time – Retired**
Employer:_____

Address_____**Zip**_____**Phone**_____

BILLING INFORMATION: (Insurance Policy Holder)

Name:_____Date of Birth_____
Last First Initial

Address:_____
Street City State Zip

Relationship to Patient:_____Social SecurityNo.:_____

Employer:_____Position:_____Phone:_____

Emergency Contact Not Living At Home_____

Address:_____Phone:_____

Their Relationship To You:_____

Who Referred You Here:_____
Doctor's Name Phone Book Family/ Friend
Circle One

Your Family Physician's Name_____

Address_____

City_____State_____Zip code_____Phone_____

I hereby authorize that my insurance benefits be paid directly to Patrick L. Spencer, D.O., Inc. or any covered services provided by him or his assistants. I also authorize him to release to my insurance company any necessary information. I understand that I will be responsible for any and all expenses that are not covered by my insurance that occur during my care and I will pay my account in a timely manner.

SIGNATURE_____**DATE**_____