James W. Douglas, M.D.
Board Certified
Reproductive Endocrinology
Obstetrics Gynecology

NEW PATIENT REGISTATION FORM

Patient Information

First Name: ______________________________
Last Name: ______________________________
SSN: ______________________________
DOB: ______________________________
Email: ______________________________
I prefer to be called: ______________________
Address: ______________________________
City: ______________ State: ________ Zip_____
Phone: ________________Cell: _____________
Employer: ______________________________
Work Phone: ____________________________
Ok to contact at work? ☐ Yes ☐ No
Referred By:_______________________________
DL#:______________________________________
Nearest relative:___________________________
Relative's Phone: __________________________

Spouse Information

First Name: ______________________________
Last Name: ______________________________
SSN: ______________________________
DOB: ______________________________
Email: ______________________________
I prefer to be called: ______________________
Address: ______________________________
City: ______________State: _____ Zip:_________
Phone ______________Cell: __________________
Employer: ______________________________
Work Phone:______________________________
Ok to contact at work? ☐ Yes ☐ No
DL#:______________________________________

Section II: Responsible Party/Insurance

In order to control your cost, charges or co-pays for office visits are to be paid at the time of service.

Will you be paying by: ___ Check ___ Cash ___ Charge

Are you covered by Medicare? ☐ Yes ☐ No Medicaid ☐ Yes ☐ No

Private insurance? ☐ Yes ☐ No Through your work? ☐ Yes ☐ No

Name of Insurance____

Responsible Party Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Address of Insurance ____

Group Number ___________________________ I.D. Number________________________________

Insurance Phone Number ____

I am legally responsible for payment of bills made by myself or my dependants for medical care by James W. Douglas, MD, PA.

Printed Name____**Date** __________________

Signature____