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

NEW PATIENT REGISTRATION 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_____