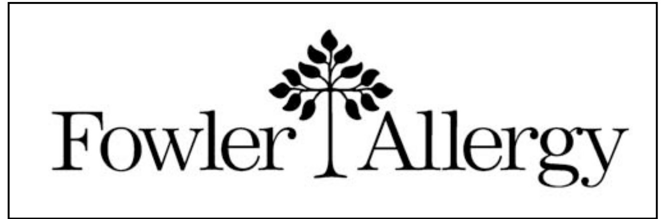
Laurie B. Fowler, M.D., P.C.
NEW PATIENT REGISTRATION FORM



Patient Name: ___________________________
Address: ________________________________
____

Social Security#________________________
Sex:__________ Birth Date:________________ Age:_______________
Marital Status: _________

How did you learn about us? __Friend __Relative __Yellow Pages Physician:_______________________

Home Phone: _____________ Work Phone/Cell: _________________________Email:_______________
Employer :____ Occupation: ___________________________

Emergency Contact:____ Relationship: ________________
Home Phone: (_____) ______________ Work Phone: (_____) _____________ Cell (_____)______________

Responsible Party or Bill To Information:
Full Name: ____ Relationship:_______________ _
Address: ____
City:____ State: _______________ Zip:______________
Home Phone: (______) ______________ Work Phone: (______) ______________ Cell (____)____________
Birth Date: ________________ Age: ________ Social Sec. #:_______________________________

Employer: ____
.
Primary Insurance:
Insurance Carrier____________________________Policy Number____________Group Number______

Subscriber's Name____________________________Subscriber's Birthdate__________SS#___________

Secondary Insurance:
Insurance Carrier____________________________Policy Number____________Group Number______

Subscriber's Name____________________________Subscriber's Birthdate__________SS#___________

Please provide the name of your primary care physician.

Dr: _______________________________________ Phone: (_______) _______________________ _

Assignment Of Benefits and Authorization To Release Medical Information

I request that payment of authorized benefits of my Insurance Carrier be made on my behalf to the provider listed on this form for any services furnished to me by the provider. Regardless of insurance reimbursement, I guarantee payment in full to my provider, under my Insurance Carrier/Provider agreement. I authorize any holder of medical information about me to release it to the listed insurer(s), and/or agents of these companies, and/or the listed responsible person(s), any information needed to determine these benefits or the benefits for other related services.

Signature:____ Date:_________________________