

CONFIDENTIAL
MERINDA HERRON, MD PC

- New Patient
 Existing Patient

REGISTRATION INFORMATION
PLEASE PRINT

Existing Patient: Revise all information
that has changed since your last visit

DATE: ____/____/____ EMAIL ADDRESS: _____ HOME PHONE: (____) _____-

PATIENT #1: _____
LAST FIRST MI

SSN: _____-____-____ SEX M F BIRTH DATE: ____/____/____

PATIENT #2: _____
LAST FIRST MI

SSN: _____-____-____ SEX M F BIRTH DATE: ____/____/____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MOTHER'S NAME: _____
LAST FIRST MI

Mother's Address: _____ Home Phone: (____) _____

Business Address: _____ Business Phone: (____) _____

Birth Date: ____/____/____ SSN: _____-____-____

FATHER'S NAME: _____
LAST FIRST MI

Father's Address: _____ Home Phone: (____) _____

Business Address: _____ Business Phone: (____) _____

Birth Date: ____/____/____ SSN: _____-____-____

FINANCIAL GUARANTOR: _____
LAST FIRST MI

Financial Guarantor's Address: _____ Home Phone: (____) _____

Birth Date: ____/____/____ SSN: _____-____-____

Address: _____

*Subscriber: _____ BIRTH DATE: ____/____/____

NAME OF SECONDARY INSURANCE CO.: _____ ID# _____ Group # _____

Address: _____

*Subscriber: _____ BIRTH DATE: ____/____/____

*Required by HIPAA

I prefer to:

- Pay my balance at the time of service Pay my balance upon receipt of first statement Make payment arrangement prior to rendering of services.

In case of emergency, who should be notified? _____ Phone: _____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ hereby authorize _____ to pay and

(NAME OF INSURED) (NAME OF INSURANCE COMPANY)
hereby assign directly to _____ all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I

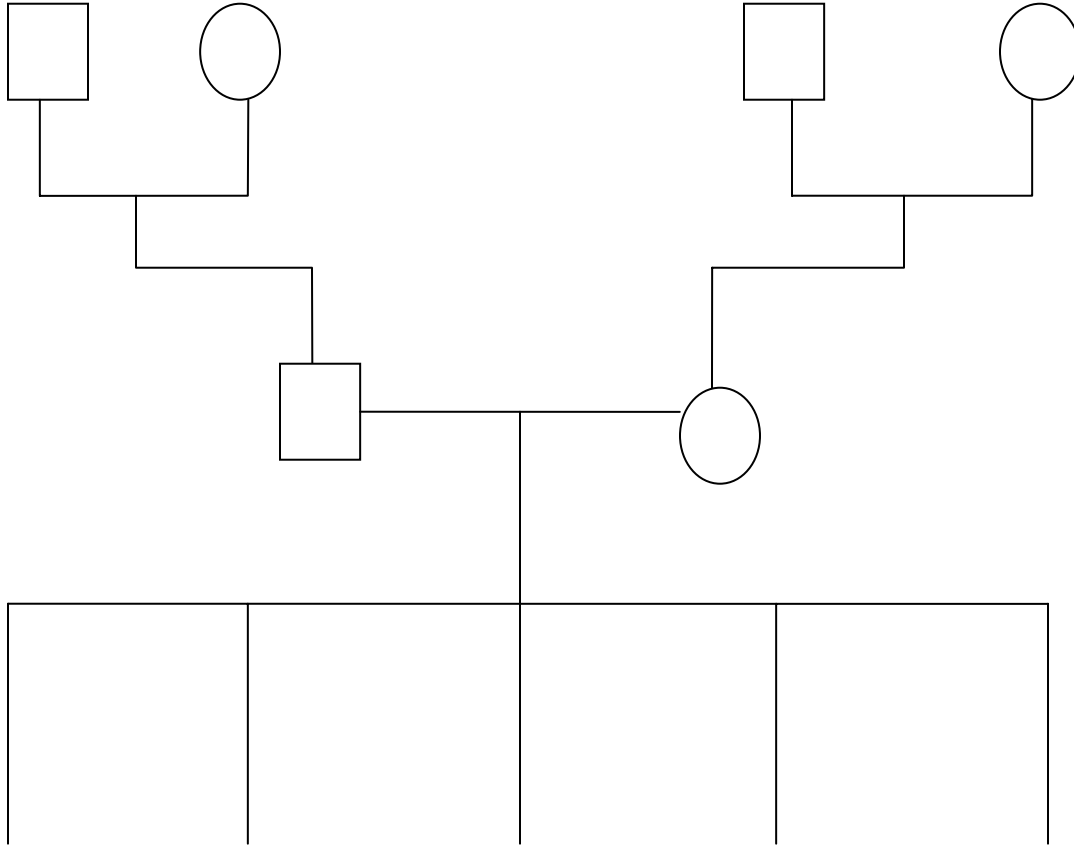
(PROVIDER'S NAME)
understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to will be credited to

(PROVIDER'S NAME) my account, in accordance with the above said assignment.

(AUTHORIZED SIGNATURE OF SUBSCRIBER)

(DATE)

FAMILY TREE



IMMEDIATE FAMILY/SOCIAL HISTORY

Diabetes	Yes	No	Eczema	Yes	No	Smoking in Family	Yes	No	Who
Cancer	Yes	No	Kidney Disease	Yes		Family Pet	Yes	No	Type
Arthritis	Yes	No	Sickle Cell	Yes		Substance Abuse	Yes	No	Type
Obesity	Yes	No	Heart Disease	Yes		Fluoride in Water	Yes	No	Community
Asthma	Yes	No	High Blood Pressure	Yes		Weapons in House	Yes	No	
Allergies	Yes	No	High Cholesterol	Yes		Smoke Detectors	Yes	No	
Hay Fever	Yes	No	Thyroid	Yes		Sudden Death Less than 40 years	Yes	No	
Mental Retardation	Yes	No	Psychiatric Disorders	Yes		Household – Who lives with patient?			
Cerebral Palsy	Yes	No	Seizure Disorder	Yes					

Please circle most recent updated year:

2000 – 2001 – 2002 – 2003 – 2004 – 2005 – 2006 – 2007 – 2008 – 2009 – 2010 – 2011