Pamela Wright, M.D., F.A.C.S.

PATIENT REGISTRATION

Please Print Clearly

Patient Name (First, MI, Last)			DOB	Age	Sex
Home Address	City	State	Zip	Home Phone	
Occupation	Social Security No.		Marital Status	Cell Phone	
Employer	Employer Address			Work Phone	
Spouse Name (or Parent)	Spouse's Employer (or Parent)			Spouse's Work Phone	
Primary Care or Family Physician Name				Telephone	
Whom may we thank for referring you to our practice?					

NOTIFY IN CASE OF EMERGENCY

Name	Relationship	Home Phone	Work Phone
Address	City	State	Zip

INSURANCE INFORMATION

Primary Insurance Company	ID or Policy Number	Group Number
Insurance Company Address	Policy Holder's SSN	Effective Date
Policy Holder's Name	Relationship	Home Phone
Policy Holder's Address	Policy Holders DOB	Work Phone
Secondary Insurance Company	ID or Policy Number	Group Number
Insurance Company Address	Policy Holder's SSN	Effective Date
Policy Holder's Name	Relationship	Home Phone
Policy Holder's Address	Policy Holders DOB	Work Phone

Please Read and Sign Our Financial Policy Authorization and Agreement on Reverse

Patient Name:_____

AUTHORIZATION OR ASSIGNMENT OF BENEFITS

I authorize Pamela Wright, M.D. to apply for benefits from _____(insurance carrier) and further authorize payment directly to Pamela Wright, M.D. (or in the case of Medicare Part B benefits, to me or to the party who accepts assignment) of the surgical and/or medical benefits, if any, otherwise payable to me for services rendered by Pamela Wright, M.D. Medicare Only: I request that payment of authorized Medigap benefits be made either to me or on my behalf to Pamela Wright, M.D.. I authorize any holder of medical information about me to release to _____ (Medigap insurer) any information needed to determine those benefits or benefits payable for related services.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of medical information required by my insurance carrier (or, in the case of Medicare Part B benefits, to the Social Security Administration and the Health Care Financing Administration) or its designated review agent, or (if applicable) my employer's worker's compensation insurance carrier in order to determine benefits to which I may be entitled, or to designated agents of Pamela Wright, M.D.. This authorization may be revoked either by me or by the above carrier at any time in writing.

FINANCIAL AGREEMENT

I hereby assume financial responsibility for and agree to make payment in full to Pamela Wright, M.D. for any and all charges for services or medical supplies received by me and/or any dependents not otherwise authorized or paid by my insurance carrier. Payment is to be made within 30 days as statements are presented with settlement in full, or payment arrangements to be made with the Billing Office. I certify that the financial information given is true, accurate, and complete to the best of my knowledge, and further authorize, Pamela Wright, M.D. to investigate any and all financial information given concerning this or related claims. I further understand that Pamela Wright, M.D. reserves the right to charge interest and/or pursue delinquent accounts via third party collection agencies or attorneys and that I am responsible for fees and/or court costs incurred by Pamela Wright, M.D. during the collections process.

I also agree to notify Pamela Wright, M.D. of any changes in my billing address or telephone and/or my health insurance carrier information as they occur.

This entire authorization is valid for all episodes of care rendered by all and any providers associated with Pamela Wright, M.D.. I permit a copy of this authorization and agreement to be used in place of the original.

Year	Signature of Patient	Date of Signature
2009		
2010		
2011		
2012		