RUTH HASKINS, MD, INC.

PATIENT REGISTRATION

Patient Name	Today's Date	Date of Birth	Age
Driver's License No.	Place of Birth		
Home Address	City	State	Zip
Mailing Address if Different	City	State	Zip
Home Phone Number	Work Phone Number	Cell Phone Number	
Occupation	Employer's Name		
Employer's Address	City	State	Zip
Spouse Name	Employer		
Primary Care Doctor			
Whom May We Thank for Referring You to Our Practice?			
NOTIFY IN CASE OF EMERGENCY			
Name	Relationship		
Address	City	State	Zip
Home Phone Number	Work Phone Number	Cell Phone Number	
Nearest Relative (not living with you)			
Home Phone Number	Work Phone Number	Cell Phone Number	
FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES			
Name	Telephone		
Address	City	State	Zip
Insurance Company	Claim Address		
Subscriber's Name	Subscriber's Date of Birth	Subscriber's ID#	
Insurance ID No.:			
Secondary Insurance	Claim Address		

Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#

I hereby assign all medical and/or surgical benefits to which I am entitled, Including Medicare, private insurance, and any other plan, to Ruth Haskins, MD, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. I hereby authorize Ruth Haskins, MD, Inc. to perform any medical treatment as deemed necessary.

Signed: _____ Date: _____