JACK M. THOMAS, M.D.

Patient Registration Form

Date: ______________________________ Social Security Number: ___________________________

Patient Name: (Last) ____________________________(First)______________________(Middle)__________

Date of Birth: __________________________________ Age: ________________________ Sex: ☐ M ☐ F

Name of Responsible Party: ___________________________ Relationship: _______________________________________

Physical Address: ____________________________________ City & State: ____________________ Zip: ______________

Mailing Address: _____________________________________ City & State: ____________________ Zip: _____________

Home Phone Number: ________________________ Alt. Phone Number (Cell Phone): ____________________________

Email: ____

Primary Insurance Company: _________________________ Secondary Insurance Company: _________________________

Name of Employer: _________________________________ Work Phone Number: ________________________________

Reason for Visit: ___________________________________ Date of Injury: _______________________________________

Brief Description of Problem: ____

Are You Being Seen As the Result of an **On-The-Job Injury**? ☐ Yes ☐ No

Are You Being Seen As the Result of a **Motor Vehicle Accident**? ☐ Yes ☐ No

Have You Had an XRay, MRI, or CT Scan of the Affected Area in the **Past Six Months**? ☐ Yes ☐ No
Films Brought? ☐ Yes ☐ No

Is there a **Pending Lawsuit** regarding this injury? ☐ Yes ☐ No

Who is your Primary Care Physician: ________________________ Primary Physician Phone Number: _________________

How did you hear about us? ____

♦♦♦

I request payment of authorized benefits be made to JACK M THOMAS, MD, and I authorize the clinic to release all necessary information to my insurance company in order to determine the benefits payable for related services.

Patient Signature: X____

Revised 01/11/17