STEPHEN W. DUNCAN, M.D.

1845 Jaclif Court. Tallahassee, FL 32308

TELEPHONE
(850)325-1212

FAX
(850)325-1375

PATIENT REGISTRATION FORM

Date: ___________

Name: ____ DOB: __________

Address: ____

City, St, ZIP: ____

Home Phone: (____)_____________ Work Phone: (____)_____________

Cell Phone: (____)______________ Social Security #: ______________

Email Address: ____

Martial Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Emergency Contact: ______________________Phone #:(___)__________

How did you hear about us?: ______________________________________

Insurance Name: ____

Policy #: ________________________________Group #: ________________

STUDENT INFORMATION

Name of Parent or Guardian: ______________________________________

Address: ____

City, St, ZIP: ____

Home Phone: (____)________________Work Phone: (____)_____________

I authorize Dr. Stephen Duncan to treat me as necessary. I authorize any information necessary to be released to my insurance carrier for this or a related claim. I request payment of medical insurance benefits to the party who accepts assignment. Accept responsibility for all co-payments and deductibles due at the time of service. I agree to be responsible for any balance not covered by my insurance carrier or responsible party.

( ) I have received a copy of "Notice of Provider Privacy Practices" handout.

PATIENT SIGNATURE:______________________________DATE:__________