Welcome to our office
Thank you for completing this form

Required Patient Information

Patient Name____ Soc. Sec #___________________________
Last First MI

Address ____

City _________________________________ State ________________ Zip ____________________________

Age________ Date of Birth______________ Sex _____ Marital status: s ☐ m ☐ d ☐ w ☐ dp ☐

Height: ___________________ Weight: ___________________ Date: ____________________ _____

Home phone_________________________________ Cell phone __________________________________

Work phone_________________________________ Best # to reach you ____________________________

Email ____

May this email be used to notify you of news, updates or specials? Yes ☐ No ☐

Employer____ Occupation ______________________________

Business address ____

Name of parent if patient under 18 ____

Emergency contact ____
Name Relation to patient phone

Referred by ____
If newspaper, yellow pages, friend please be specific

Primary Care Physician ____

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Insurance Information

Medicare number ____

Primary Insurance______________________________________ ID/group# ________________________

Subscriber name ____Date of birth ___________________

Secondary insurance ____________________________ ID/group #______________ Co-pay____________

Financial Assignment and Agreement

I hereby give indefinite authorization for payment of insurance to be made directly to Paul T. Stallman, MD, Inc. for services provided. I understand that I am financially responsible for all charges whether or not paid by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize the release of all information necessary to secure the payment of benefits. I understand that failure to provide this office with current insurance information may result in my being responsible for all charges.

Signature of responsible party ____ Date ___________________