Gregory E. Cox M.D. LLC

Patient Registration Information

Name _____Birthdate_____ SSN _____
Last Name First Name Initial

Home Phone _____Cell Phone _____ Email _____

Address _____City _____State ____

Sex: □ M □ F □ Minor □ Single □ Married □ Divorced □ Widowed Zip Code_____

Employer _____ Work Phone _____

Business Address _____Occupation_____

Who Should We Thank For Referring You? _____

In Case Of Emergency, Who Should We Contact? _____
Name Phone

Primary Insurance

Person Responsible For Account _____ SSN _____
Last Name First Name Initial

Relationship to Patient _____Birthdate _____

Home Phone _____Cell Phone _____ Email _____

Address _____City _____State _____Zip Code _____

Responsible Party Employed By _____ Work Phone_____

Business Address_____ Occupation_____

Insurance Company _____ Subscriber ID# _____ Group# _____

Insurance Co. Address _____

Additional Insurance (If Applicable)

Insured Name _____Relationship To Patient _____Birthdate _____
Address _____ City _____ State _____ Zip _____
Insured Employed By _____ Work Phone_____
Insurance Co. _____Subscriber ID# _____ Group# _____
Address _____

Assignment And Release

I hereby authorize payment directly to Dr. Gregory E. Cox LLC all insurance benefits, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents. I authorize the above noted doctor to release any information required to secure the payments of benefits. I authorize this signature on all insurance.

Signature Of Responsible Party _____Date _____