Office of Titus A. Taube, MD

Family Medicine

Titus A. Taube, MD
200 S. Houston Lake
Road, Suite B

Phone: (478) 953-1800
Fax: (478) 953-1931

PATIENT REGISTRATION FORM

Please complete this form front and back – please print.

PATIENT INFORMATION

Patient Name: ____________________

Address: ____________________ **City:** ____________________

State: __________ **Zip:** ________ **E-Mail:** ____________________

Home Phone: __________ **Cell:** __________ **Work:** __________

Date of Birth: __________ **SS#:** __________

Emergency Contact: ____________________ **Phone:** __________

EMPLOYER INFORMATION

Employer Name: ____________________ **Supervisor Name:** __________

Address: __________ **City:** __________ **State:** __________

INSURANCE INFORMATION

Name of Primary Insurance Company: ____________________

Member ID: ____________________ **Group #:** __________

Policy Holder's Name: ____________________ **Date of Birth:** __________

Policy Holder's Employer: ____________________ **Policy Holder's SS#:** __________

Name of Secondary Insurance Company: ____________________

Member ID: ____________________ **Group #:** __________

Policy Holder's Name: ____________________ **Date of Birth:** __________

Policy Holder's Employer: ____________________ **Policy Holder's SS#:** __________

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BILLING INFORMATION

Patient Name: ______________________________

Responsible Party Name: ______________________________

Address: ______________________________ **City:** ____________

State: ____________ **Zip:** ____________

Home Phone: ____________ **Other Phone:** ____________

Date of Birth: ____________ **SS#:** ____________

ASSIGNMENT OF BENEFITS

Your signature is necessary for us to process any insurance claims to insure payment of services rendered.

The Insured Patient: I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to Titus A. Taube, MD and/or any other medical provider in this office. 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.

The Uninsured Patient: All payment is due at the time of visit for any medical or surgical services furnished by any physicians or providers at this office.

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Titus A. Taube will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient Signature: ______________________________ Date: ____________