Mary McDonald, M.D., S.C.
Gastroenterology & Hepatology

PATIENT REGISTRATION

Patient Name: ____ Date of Birth___/___/___
(Legal name) (Last) (First) (Middle Initial)

Sex: ☐ Male ☐ Female

Mailing Address:

____
(Street) (City) (State) (Zip)

Telephone #: Home: ___________________________

Work: ___________________________ Cell: ___________________________

*Please initial here to authorize the office of Mary McDonald, M.D., S.C. to leave messages on your home answering machine: ___________

Social Security #: ______________________________________

Place of employment: __________________________________

Marital Status: ☐Single ☐Married ☐Other Spouse name: _________________________

Primary Physician: ____________________________

Pharmacy: ___________________________________ ___________________________________
(Name) (City/Town)

Emergency Contact: ____Relationship: _______________
(Someone who does not live with you)

Phone: (Home) ________________________ (Work) ________________________

Please complete reverse side.
Thank you.

PATIENT INSURANCE INFORMATION

Primary Insurance: ______________________________ Subscriber: __________________________________

Insurance mailing address: ____
(Street) (City) (State) (Zip)

Policy Number: _________________________ Group Number: __________________________

Subscriber Date of Birth ___/___/___
Subscriber social security number: _______________________________________
Subscriber Address (if different from the patient):

____
(Street) (City) (State) (Zip)

Secondary Insurance: ____________________________Subscriber: ___________________________________

Insurance mailing address: ____
(Street) (City) (State) (Zip)

Policy Number: ___________________________ Group Number: __________________________

Subscriber Date of Birth: ___/___/___
Subscriber social security number: ____
Subscriber Address (if different from the patient):

____
(Street) (City) (State) (Zip)

ASSIGNMENT OF INSURANCE BENEFITS

THE UNDERSIGNED HEREBY AUTHORIZES THE RELEASE OF ANY INFORMATION RELATING TO ALL CLAIMS FOR BENEFITS SUBMITTED ON BEHALF OF MYSELF AND / OR DEPENDENTS. I FURTHER EXPRESSLY AGREE AND ACKNOWLEDGE THAT MY SIGNATURE ON THIS DOCUMENT AUTHORIZES MY PHYSICIAN TO SUBMIT CLAIMS FOR BENEFITS FOR SERVICES RENDERED OR FOR SERVICES TO BE RENDERED WITHOUT OBTAINING MY SIGNATURE ON EACH AND EVERY CLAIM TO BE SUBMITTED FOR MYSELF AND / OR DEPENDENTS, AND THAT I WILL BE BOUND BY THIS SIGNATURE AS THOUGH THE UNDERSIGNED HAD PERSONALLY SIGNED THE PARTICULAR CLAIM.

I HEREBY AUTHORIZE MY INSURANCE COMPANY, _________________, A MEDIGAP INSURER TO PAY AND HEREBY ASSIGN DIRECTLY TO MARY MCDONALD, M.D., S.C. ALL BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR HER SERVICES. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED. I FURTHER ACKNOWLEDGE THAT ANY INSURANCE BENEFITS, WHEN RECEIVED BY AND PAID TO MARY MCDONALD, M.D., S.C., WILL BE CREDITED TO MY ACCOUNT IN ACCORDANCE WITH THE ABOVE SAID ASSIGNMENT.

____ ____________________
(AUTHORIZED SIGNATURE) (DATE)

____
(If signed by a person other than patient, state relationship and authority to do so.
Also complete the following section.)

Responsible Person: ____
(Last) (First) (Middle Initial)

Address: ____
(Street) (City) (State) (Zip)

Telephone #: Home: _________________________ Work: __________________________