Julye Nesbitt Carew, M.D, P.A. • Michelle Chesnut M.D, P.A.

Patient Registration

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Home Address: _____
Street Apartment # City State Zip Code

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Best Contact # (circle one): Home Work Cell

Email: _____@_____

Occupation: _____ Employer: _____

Married Divorced Widowed Single Life Partner

SPOUSE INFORMATION (please complete if patient is not primary insurance holder)

Spouse Name: _____ Date of Birth _____

Employer: _____

Best Contact Number: _____

INSURANCE INFORMATION (Please fill everything out even though a copy will be obtained)

Primary Insurance: _____

Secondary Insurance: _____

Tertiary Insurance: _____

OTHER INFORMATION

Emergency Contact: _____ Emergency Contact #: _____

Pharmacy Name: _____ Phone Number: _____

Primary Physician: _____ Referred By: _____

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NOTICE OF INSURANCE VERIFICATION AND REFERRALS

I _____, understand that as the insured individual, it is my responsibility to verify that my physician is "in network" according to my insurance plan(s) and notify the office immediately of any changes in my insurance coverage. It is my responsibility to obtain required referrals prior to the date of service and ensure my referral is current on date and number of visitations. If I am seen "out of network" and/or without a valid referral, I understand my insurance company may not pay for the services rendered, and I will be liable for all charges incurred.

_____	**X**_____	_____
Patient Name Printed	Patient Signature	Date

AUTHORIZATION OF DISCLOSURE

I_____, authorize the full disclosure of my entire medical record including but not limited to patient histories, office notes, test results, radiology studies, films, studies, consults, alcohol/drug treatment, mental health information, HIV-related information, billing records, insurance records, and records sent by other physicians to the following individuals:

_____	_____	_____
Name of Individual	Relationship to patient	Contact number
_____	_____	_____
Name of Individual	Relationship to patient	Contact number
_____	_____	_____
Name of Individual	Relationship to patient	Contact number

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of the disclosure. Information re-disclosed by the recipients listed in this authorization will not be the liability of the physicians. Authorization may be revoked in part or in full at any time with written authorization by the patient.

_____	**X**_____	_____
Patient Name Printed	Patient Signature	Date

NOTICE OF CHARGE FOR MISSED APPOINTMENTS

Our office will charge a **$45.00 fee for a missed appointment** that is not cancelled 24 hours prior to the appointment time.

I acknowledge this policy:

_____	**X**_____	_____
Patient Name Printed	Patient Signature	Date