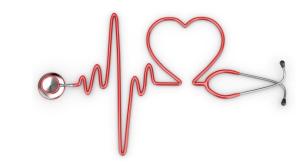
Chart Number	

WILLIAMS COMPREHENSIVE HEALTHCARE PLLC



PATIENT REGISTRATION

(This information is needed to properly file your insurance. Please answer completely and print neatly. Questions should be answered in the space below the question. Any inaccurate or incomplete information may result in a denial by your insurance company and you being billed personally for services.)

Date		PATIENT INFORMATION				Patient's Social Security #				
PATIENT: Last Name				First Name		M.I.	Preferre	ed Prefix	Sex	
		Mr.				Mr.	Ms.			
							Mrs.	Miss		
	Str	eet Address					Birthdate		Age	
Officer Address										
City		State	Zip Code	Zip Code Home Telephone		Mobile Telephone		Work Telephone		
,			•		•		•	•		
Employer	Employer Employer's			Address			Occupation		Marital Status	
E-Mail A	Address		OTHER CONTACT: Name			Relationship		Telephone Number		
							·	•		
In case of emergency, who may we contact who does not live wit			with you? What is your pre				oreferred pharmacy?			
Name Telephon		ne Number Name			ame	Telephone Number				
	(Complete	this section i	RESPO f you are listed	NSIBLE P d as a deper		neone else's	,	o Portulo Socio	l Soourity #	
IS THIS THE RESPONSIBLE F	PARTY FOR:					Responsible Party's Social Security #		i Security #		
PRIMARY INSURANCE		ARY INSURA	NCEBO	TH						
RESPONSIBLE PARTY: Last	RTY: Last Name M.I. Prefer			Preferre	ed Prefix	Sex				
						Mr.	Ms.			
							Mrs.	Miss		
Street Address				Birt	hdate	Relationship To Patient				
City		State Zip Code			Home Telephone		Work Telephone			
Employer				Employer's Address Marita				Marital	Status	
p.c.jc.										

INSURANCE INFORMATION

Please provide our front desk with your insurance card so that it may be copied. Thank you.

PRIMARY INSURANCE

Insurance Company	Insured	Polic	<i>/</i> #	Group #		Deductible	Co-Pay
Street Address for cla	ims:	City	1	State	Zip	Telephone	e Number
					-	-	
Please specify your insurance company	's preferred lab. (N/A for Mo	edicare)		Is Prior Au	thorization Req	uired for Care?	
	SECONE	DARY INSUR	ANCE				
Insurance Company	Insured	Polic	/ #	Gre	oup #	Deductible Co-Pay	
Street Address for cla	ims:	City	1	State	Zip	Telephone	e Number
have listed them above. If any charges remain unpaid because I have no does not cover the charges, I agree to be person the plan. This statement remains in effect until	nally liable for said charges.	The above lang	uage does n harges on m	ot apply to co	ntractual adjustn paid and I am r	nents of allowed	charges under
Date			Patie	envkespons	sible Party		
My signature below indicates that I have been of review. Unless I disagree below, I agree that my way limiting the scope of the Confidentiality Policy prescriptions may be faxed to pharmacies, recording billing and collecting assigned claims and metindividual answering the phone who identifies his personal cell phone answering machine. Further Twitter provided no confidential medical information account are paid and I am no longer a patient.	y protected health information by, I specifically agree the officed ds may be released to any consages may be left at my how man mobile number or ema	lotice of Privacy may used according may used according may release ompany who is not on my permy family such ill address may	Practices Fording to the my records expected to sonal cell phas a spouse oe added to	for Protected In policies iteminate to other healt pay for service none concerning or parent. Me social media	zed in the Confiders he care providers es rendered to many appointments essages may also accounts of this	dentiality Policy. involved with my ne and to compa and test results so be left on my provider such as	Without in any y care, nies involved provided the home or s Facebook and
Date			Patient/Responsible Party				
My records may not be used according	to the practice's privacy	policies in th	ne followir	ng ways:			
How did you find out about us?							
Is there any additional information we n	eed to properly file your	insurance?					