STRICK MAYS M.D.|SUE GRIFFIN, ARNP
REGISTRATION FORM

WE REGRET THAT WE ARE UNABLE TO ACCEPT NEW PATIENTS WEIGHING OVER 300 POUNDS DUE TO EQUIPMENT RESTRAINTS

Today's date: | PRIMARY CARE PHYSICIAN:

PATIENT INFORMATION

Patient's last name: First: Middle: | Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | CELL # ( ) | Birth date: / / | Age: | Sex: ☐ M ☐ F

Street address: | Social Security no.: | Home phone no.: ( )

P.O. box: | City: | State: | ZIP Code:

Occupation: | Employer: | Employer phone no.: ( )

PLEASE CIRCLE ONE: FULLTIME PARTTIME UNEMPLOYED DISABLED RETIRED ACTIVE DUTY

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. ☐ Insurance Plan ☐ Hospital

☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

If is a minor name of responsible. Name________________________, phone #______________,SSN____________

Address_________

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( )

Occupation: | Employer: | Employer address: | Employer phone no.: ( )

Please indicate primary insurance ☐ BCBS ☐ MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CIGNA

☐ FIRST HEALTH ☐ AETNA ☐ STAR BRIDGE ☐ Welfare *(Please provide coupon)* ☐ Other

Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable): | Subscriber's name: | Policy or Contract # | Group#

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Mays & Sue Griffin or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

E-MAIL ADDRESS ________________________

WHAT PHARMACY DO YOU USE ? ________________

LOCATION ? ________________