# Brad Moore, MD Obstetrics & Gynecology, PC
# Patient Registration Form

Name _____ Today's Date _____
Last First MI

Street Address _____ Apt# _____ City _____

State _____ Zip _____ Home Phone # _____

Cell Phone _____ Other Contact # _____

Date of Birth _____ SS# _____ Email _____

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Ins. Comp. _____ Insurance Policy # _____

Who's responsible for payment _____ Group # _____

Significant Other's Name _____ SS# _____

Sig. Other Employer _____ Best Phone # _____

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Emergency Contact (friend or relative not living with you): _____

Address _____ Phone # _____

Pharmacy _____ Phone # _____

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How did you hear about us? Another patient _____

Internet: Google Kudzu.com CallaDoctor.net Other _____

Yellow Pages Physician Referral _____ Other _____

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I hereby consent to medical treatment by Brad Moore M.D. Obstetrics and Gynecology, P.C. (BMOG). I also authorize BMOG or any holder of medical or other information about me to release to my insurance company information required in the course of my treatment for processing this or a future medical claim. I hereby authorize direct payment of any benefits payable for these medical services. I understand that I am financially responsible for payment of all services rendered regardless of insurance coverage and that I may be accountable for late fees and penalty charges for balances more than sixty days outstanding. I also realize that if my account is more than 60 days overdue I will be discharged from this medical practice and be unable to receive medical care at BMOG in the future. I have been given a copy of BMOG's privacy policy and have had any questions about HIPPA laws answered.

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Signature _____

Is it okay to leave test results on your voicemail or answering machine? Yes No

*We are honored that you have chosen us as your health care provider.*