James Joyner, M.D.

Confidential Information

Patient Name: _____

Address: _____

City, State, Zip: _____

Phone: ( ) _____ Date of Birth: _____ M [ ] F [ ]

Social Security: _____ Student Status: Full Time [ ] Part Time [ ]

Occupation: _____ Employer: _____

Work Address: _____

City, State, Zip: _____

Work Phone: ( ) _____ Ext.: _____ Cell Phone: ( ) _____

Marital Status: Single [ ] Married [ ] Other [ ] E-mail: _____

Language: _____ Race: _____

Emergency Contact: _____

Relationship: _____ Phone: ( ) _____

Referred By: _____

If married or legal guardian please complete below:

Name: _____ Relationship: _____

Date of Birth: _____

Work Phone: ( ) _____

INSURANCE INFORMATION

Insurance Company: _____ Policy Number: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber's Sex: M [ ] F [ ] Subscriber's Relationship to patient: _____

Insurance Company: _____ Policy Number: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber's Sex: M [ ] F [ ] Subscriber's Relationship to patient: _____

Workman's Comp. Claim: Yes [ ] No [ ] Insurance Carrier: _____

Date of Injury: _____ Auto Accident: Yes [ ] No [ ]

If Subscriber's address is different from patient please fill out below:

Address: _____

City, State, Zip: _____

Phone: ( ) _____

Do you smoke? [ ] No [ ] Yes [ ] Past – How long ago?_____

Medications

Drug allergies: [ ] No [ ] Yes To what? _____

_____

Type of Reaction: _____

Present medications (List any medications you are taking, including over-the-counter medications.)

Name of Drug	Dose	How medication is taken
Example- Tylenol	***325mg***	***1-2 tablets every 4-6 hours***
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

I authorize release of confidential medical information to the following contact persons:

Name: _____ Name: _____

Phone: ( ) _____ Phone: ( ) _____

Relationship: _____ Relationship: _____

I verify that the above information is correct. I understand that I am financially responsible for all charges, regardless of insurance coverage. I request that payment of insurance benefits be made on my behalf to: ***James Joyner, M.D.*** *for any services furnished to me.*

Signature of Patient/ Legal Guardian: _____ Date: _____

I authorize ***James Joyner, M.D.*** *to disclose/request my health information including copies of records as necessary to/from:*

1. *Any health insurance plan, company of billing service that provides insurance coverage for me for the purpose of payment of charges.*
2. *Consulting and treating physicians, diagnostic facilities, labs, radiology/imaging, outpatient facilities and hospitals and other health providers for the purpose of continuity of care.*
3. *Any insurance company that provides liability insurance coverage for* ***James Joyner, M.D.*** *to evaluate clinical performance.*
4. *Any worker's compensation, no fault, or administrative proceeding for the purpose of evaluating my medical condition.*

All medical information with no exceptions, will be disclosed/requested as necessary to/from the above. I authorize faxing of information as necessary. This authorization shall cover the period of time from my first visit to my last visit and will end two (2) years after the date of my last visit. I permit a copy of this authorization to be used in place of the original.

Signature of Patient/ Legal Guardian: _____ Date: _____