Date: _____ (Please Print) Home Phone: _____

Name: _____
Last First MI

Street Address: _____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

SS#: _____

Age: _____ Birth date: _____ Marital Status: M S W D (circle one)

Responsible party (if minor): _____

SS#: _____ Date of birth: _____

Home phone: _____ Work phone: _____

Cell phone: _____

Employer: _____ Occupation: _____

Business address: _____ Business phone: _____

Spouse: _____ Address: _____

Employer: _____ Business phone: _____

Business address: _____

Do you have medical insurance? ___ Yes ___No Name of Ins. _____

Name of Policy Holder: _____

Date of Birth of Policy Holder: _____SS#_____

Name of Secondary Insurance: _____

Date of Birth of Policy Holder: _____SS#_____

In emergency notify, other than spouse: _____ Phone: _____

Your drugstore: _____ Primary Physician: _____

I hereby authorize David M. Hampton, MD, PA, to furnish my insurance company all information which might be requested. I hereby assign to David M. Hampton, MD, PA, benefits paid by my insurance to be applied to, but not to exceed, my indebtedness. I understand that I am financially responsible for all charges incurred. I understand that all services are payable at the time of service unless prior arrangements have been made. I agree to pay all expenses incurred should this account be turned to an attorney.

_____
Patient's signature (18 or older)

Responsible party's signature if patient is a minor: _____