Mark L. Ginnings, MD

Patient Information Page

****PLEASE PRINT****

Name: _____ Sex M F

Last First Middle Int.

Social Security # _____ DOB: _____ Age: ____

Home Ph# _____ Cell. # _____

Mailing Address: _____

_____

City State Zip

How do you prefer to be contacted? Check one:

___ Home ___ Cell Phone:

E-mail Address: _____

Pharmacy Preference: _____

Name of Employer: _____ Work Ph #: _____

Emergency Contact: _____ Relationship: _____

Emergency Phone #: _____

PATIENT'S INSURANCE INFORMATION SELF PAY

Primary Insurance	Secondary Insurance
Name:	Name:
Ins. Ph #	Ins. Ph #
Name of Insured:	Name of Insured:
Insured's Relationship:	Insured's Relationship:
Insured's ID#:	Insured's ID#:
Insured's DOB:	Insured's DOB:

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, private insurance and any other health plan, to Mark L. Ginnings, MD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure payment.

Signature: _____ Date: _____