

Hugh C. McLeod III, M.D.
PLEASE PRINT FRONT and BACK

PATIENT INFORMATION

PATIENT	LAST	FIRST	M.I.	SOCIAL SECURITY NUMBER
DATE OF BIRTH	MARITAL STATUS	MALE/FEMALE		EMPLOYER
STREET			APT#	STREET
CITY		STATE	ZIP	CITY STATE ZIP
HOME PHONE ()		WORK PHONE ()		
CELL PHONE ()		CONTACT PHONE FOR APPTS ()		

PRIMARY POLICY HOLDER (OMIT IF SAME AS PATIENT)

LAST	FIRST	M.I.	REALTIONSHIP	DATE OF BIRTH	SOCIAL SECUTRIY NUMBER
STREET			APT#	EMPLOYER	OCCUPATION
CITY		STATE	ZIP	STREET	
HOME PHONE ()	WORK PHONE ()		CITY	STATE	ZIP

IF PATIENT IS A MINOR COMPLETE THE FOLLOWING

MOTHER'S NAME	FATHER'S NAME
PERSON TO BE CONTACTED FOR APPTS	DAY TIME PHONE ()

EMERGENCY CONTACT RESIDING AT A DIFFERENT ADDRESS (ie. Friend or Relative)

LAST	FIRST	M.I.	RELATIONSHIP	HOME PHONE	WORK/CELL PHONE
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PRIMARY DOCTOR

LAST	FIRST	PHONE ()
STREET		CITY STATE ZIP

PLEASE READ AND SIGN

AUTHORIZATION TO RELEASE INFORMATION: I herby authorize the office of Dr. Hugh C. McLeod III to release my insurance company information acquired in the course of my examination or treatment.

AUTHORIZATION OF INSURANCE BENEFITS: I hereby authorize payment of my insurance directly to the office of Dr. Hugh C. McLeod III of the surgical and /or medical benefits, if any, otherwise payable to me for his services as described on this form. I understand that, other than Medicare Assignment, I am financially responsible for those charges not paid by my insurance. I realize that my insurance is a contract between the insurance carrier and myself, and the fee is due to the doctor regardless of the amount paid by insurance. A COPY OF THIS SHALL BE VALID AS THE ORIGINAL.

SIGNATURE (PATIENT OR PARENT IF A MINOR)

DATE

NAME _____ TODAY'S DATE _____

Is this injury the result of a specific accident?
YES or NO

Part of Body Injured--- _____ (**RIGHT or LEFT**)

Home/Other (ie. Gym, Sports, School, etc.) *circle one*

Date of injury _____

Place of injury _____

How accident/injury occurred _____

Work (if injury occurred at work you must file a work comp claim because your regular medical insurance will **NOT** pay for this visit.)

_____ _____ _____
Work Comp Ins Claim Number Phone Number

Was an injury report filed to your employer? **YES or NO**

Date of injury _____

How accident/injury occurred _____

Car Accident

Was a claim filed to the car insurance company? **YES or NO**

Who is the at fault party? _____

_____ _____ _____
Car Insurance Comp Claim Number Phone Number

Date of injury _____

How accident/injury occurred _____

