KELLY W. HUBBARD M.D., P.C.   JEFFREY C. BAUGH, PA-C   ADRIENNE MCMASTER, PA-C

PATIENT INFORMATION

Name________________________________Soc.Sec.No.___________________________Date______________

Address____________________________________City_____________________State_____Zip___________

Billing Address (if different) _________________________________City_______________State_____Zip_____

Phone_____________Cell Phone ___________Birthday___________ (Circle) M F Married-Single-Widowed-Divorced

Race_____________________________Ethnicity_________________________Language___________________

Email___________________________ Primary Care Physician___________________Phone__________ ______

Name & Address of Employer____Wk.Phone _________

Spouse (or) Parent Name ____Soc.Sec.No.____________________

Spouse (or) Parent Employer____Wk.Phone__________

Emergency Contact____Phone___________________

Person Responsible for Account____________________________email__________________________________

Do we have your permission to:

Leave a message on your answering machine at home? Yes ☐ No ☐

Leave a message at your place of employment? Yes ☐ No ☐

Discuss your medical condition with any member of your household? Yes ☐ No ☐

If yes, Whom:____Relationship:___________________

INSURANCE INFO

PRIMARY Insurance Company________________________________Policy or I.D. No.________________

Name of Policy Holder____________________________Birthday_____________Soc.Sec.No._____________

Insurance Co. Address____Phone___________________

SECONDARY Insurance Co.____Policy No.__________

Name AND Birthday of Policy Holder__________________________________Soc.Sec.No._______________

Insurance Co. Address____Phone___________________

Authorization to Treat and Insurance Policy

We will be happy to submit all insurance claims if you provide us with your COMPLETE insurance information at the time of your visit. You are responsible for all co-pays, deductibles, and charges not covered by insurance. It is our policy to require payment on all office charges at the time they are given, unless prior arrangements have been specifically made... In the event of default and referral to an attorney or collection agency, I agree to pay all collection cost including reasonable attorney fees. I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of insurance benefits otherwise payable to me directly to the doctor. * I give the consent for Dr. Hubbard, Jeffrey C. Baugh and/or Adrienne McMaster to treat me or my child.

**** I understand that this office is in compliance with all HIPPA regulations, and a brochure and full disclosure is available to me upon request.**

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Signature of Patient (or parent if minor)   Date