DAVID L. HIGGINS, M.D., P.C.

PLEASE PRINT LEGIBLY

PERSONAL INFORMATION:

Name: First: _____ **M.I.** ___ **Last**: _____ **Birth Date**: ___/___/_____

Age: _____ **Gender**: M_____ F_____ **Social Security #:** _____/_____/_____

Address: _____ **City**_____ **State** _____ **Zip** _____

Email: _____ **Occupation**: _____FT PT Retired

Marital Status: S___ M___ W___ D___ Sep___ **Student Status:** FT___ PT___ **School**:_____

Employer Name & Address: _____

Spouse Name: _____ **Spouse Employer**: _____ **Phone #:** _____

Emergency Contact: _____ **Phone #:** _____ **Relationship**:_____

Primary Care Physician:_____ **Phone #:** _____

If medications are prescribed, what pharmacy would you like us to use? ***Please be specific ...***

Pharmacy Name: _____ **Location**: _____

How did you hear of Dr. Higgins? _____

CONTACT INFORMATION:

Home #: _____ **Cell #:** _____

Do you authorize us to leave messages regarding medical treatment/appointments/billing? YES_____NO___

If over the age of 18, who do you authorize the office to speak with?: *Please choose all that apply

Spouse _____ **Parent(s)** _____ **Other (please specify)** _____

May we contact you at work? YES _____ NO _____ If YES, what is your work #?: _____

BILLING INFORMATION:

Person/Guardian responsible for bill (if other than patient) Name: _____

Address (if different from patient): _____

INSURANCE INFORMATION:

Circle all that apply: Self Pay Worker's Compensation Auto Insurance

PRIMARY INSURANCE: _____ **MEMBER ID #/Policy #:** _____

POLICYHOLDER'S NAME: _____ and **DATE OF BIRTH**: _____

POLICYHOLDER'S #: Home: _____ **Cell #:** _____ **Work #:** _____

SECONDARY INSURANCE: _____ **MEMBER ID#/Policy #:** _____

POLICYHOLDER'S NAME: _____ and **DATE OF BIRTH:** _____

PATIENT SIGNATURE: _____ **DATE**: _____