

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

PLEASE PRINT LEGIBLY

PERSONAL INFORMATION:

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

Age: _____ Gender: M___ F___ Height/Weight: _____ Social Security #: ___/___/___

Address: _____ City _____ State _____ Zip _____

Email: _____ Occupation: _____

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: _____ Exact Address: _____

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:

Check 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: _____