



JEFFREY E. THOMAS

M.D., F.A.C.S.

CEREBROVASCULAR, INTERVENTIONAL
AND GENERAL NEUROSURGERY

Patient Registration Form

Patient Name (Last, First MI) _____ Sex _____

Birth Date _____ Social Security No. _____

Patient Address _____

Primary Phone (____) _____ Secondary Phone (____) _____

Employer Name _____ Work Phone (____) _____

Employer Address _____

If Married, Spouse Name _____

Spouse's Phone (____) _____

Referring Physician _____

Referring Physician Address _____

Referring Phone (____) _____ Referring Fax (____) _____

Primary Care Physician (PCP) _____

PCP Address _____

PCP Phone (____) _____ PCP Fax (____) _____

Authorization

I hereby authorize Dr. Jeffrey E. Thomas to furnish information to insurance carriers concerning this illness/accident, and I hereby assign to this doctor all medical payments for the services rendered. I understand I will be responsible for all legal costs and charges incurred for any past due account. I am responsible for supplying Dr. Jeffrey E. Thomas' office proof of my effective medical insurance coverage and for updating my insurance with this office should any changes arise. I further understand that I am financially responsible for all charges in the event my insurance carrier does not pay the services rendered.

Signature _____ Date _____