Michael W. Johnston, M.D. INFORMATION SHEET

7 WINDSWEEP COURT PHENIX CITY, ALABAMA 36870 • (334) 297-5555 • WWW.DRJOHNSTONMD.COM

PATIENT'S NAME: (LAST) (FIRST) (MIDDLE)

MAILING ADDRESS: (STREET) (CITY) (STATE) (ZIP)

BIRTHDATE: (MONTH) (DAY) (YEAR) SEX: (MALE OR FEMALE) SOCIAL SECURITY NUMBER:

HOME PHONE: WORK PHONE: CELL PHONE:

MARITAL STATUS:

SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED _____ SEPARATED _____

PLACE OF EMPLOYMENT

IF YOU WOULD LIKE FOR US TO FILE YOUR INSURANCE, PLEASE PROVIDE THE FOLLOWING INFORMATION AND A COPY OF YOUR INSURANCE CARD:

NAME OF INSURANCE (IF ANY): POLICY NUMBER:

NAME OF INSURED: INSURED'S DATE OF BIRTH: INSURED'S SOCIAL SECURITY NUMBER:

IF MARRIED: SPOUSE'S NAME SPOUSE'S DATE OF BIRTH: SPOUSE'S SOCIAL SECURITY NUMBER:

SPOUSE'S EMPLOYMENT: SPOUSE'S PHONE NUMBER:

IF A MINOR: PARENT OR GUARDIAN'S NAME: DATE OF BIRTH: SOCIAL SECURITY NUMBER:

PERSON RESPONSIBLE FOR THE BILL: METHOD OF PAYMENT: CASH OR PHENIX CITY CHECKS ONLY!!

NAME OF RELATIVE OR FRIEND (EMERGENCY CONTACT): PHONE NUMBER:

I WAS REFERRED BY: (RELATIVE, FRIEND, PHONE BOOK, WEB, ETC.) REASON FOR TODAY'S VISIT:

ALLERGIES: _____ HAS ANY MEMBER OF YOUR FAMILY EVER BEEN TREATED BY DR. JOHNSTON?

_____ IF YES, NAME: _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE. WE DO FILE MEDICARE AND BLUE CROSS. ANY OTHER INSURANCE WE CAN CALL FOR BENEFITS ON AS A SERVICE. **ALL FORMS ARE FILLED OUT FOR A SMALL CHARGE.**

AUTHORIZATION: I HEREBY AUTHORIZE MICHAEL W JOHNSTON, MD TO TREAT ME. I AUTHORIZE RELEASE OF MEDICAL INFORMATION TO MY INSURANCE COMPANY. I ASSIGN BENEFITS OF ANY INSURANCE FILED BY MY PHYSICIAN TO MICHAEL W JOHNSTON, MD AND I UNDERSTAND THAT **I AM RESPONSIBLE** FOR THE CHARGES FOR SUCH MEDICAL SERVICES RENDERED.

SIGNED: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____