

Patient Information

Thank you for choosing Dr. Charles Mabray's office. In order to serve you properly, we need the following information. Please Print. All information will be confidential.

Patient Name: _____ Driver's Licenses No: _____
CIRCLE best number to remind you of appt's HOME * CELL * WORK
SS#: _____ Birthday: ____/____/____ Home #: _____ Cell #: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Patient's Employer: _____ Work Phone: _____
Spouse's Name: _____ Employer: _____ Work Phone: _____
Person to contact in case of emergency: _____ Phone #: _____
E-mail address: _____

Insurance Information

REQUIRED in order to file insurance, even though cards on file

Name of Insured _____ Relationship to Patient _____
Insured's Birthdate ____/____/____ Social Security Number: _____
Name of Employer _____ Work Phone _____
Insurance Company _____ Policy #: _____ Group# _____
Insurance Co. Address _____ City: _____ State: _____ Zip: _____
Provider Customer Service Phone Number to verify benefits: _____
Copay? Yes – No Amount: \$ _____ Deductible? Yes – No Amount per Calendar Year: \$ _____
Do you have any additional insurance? Yes No If yes, complete the following:

Name of Insured _____ Relationship to Patient _____
Insured's Birthdate ____/____/____ Social Security Number: _____
Name of Employer _____ Work Phone _____
Insurance Company _____ Policy #: _____ Group#: _____
Insurance Co. Address _____ City: _____ State: _____ Zip: _____
Provider Customer Service Phone Number to verify benefits: _____

Copay? Yes – NO Amount: \$ _____ Deductible? Yes – No Amount per Calendar Year: \$ _____

Authorization & Release: I authorize release of any information concerning my healthcare, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I authorize payment of insurance benefits made directly to C.R. Mabray, M.D. I acknowledge and understand that I am responsible for all charge incurred for all service rendered to the patient listed above.

Signature of Patient

Date Signed