

ERNEST B. ROBINSON, M.D., PC

A PROFESSIONAL CORPORATION

PATIENT INFORMATION

Name: _____ Sex: **M** **F**
Last First MI

Home Address: _____
Street Apt. City State Zip Code

Phone: _____
Home Work Cell

E-Mail: _____ Social Security #: _____

Birth Date: _____ Age: _____ Marital Status: **S M D W** Name of Spouse: _____

REFERRAL INFORMATION

How were you referred? (Check all that apply)

Patient: _____ Friend: Name: _____

Physician / Dentist: _____

Newspaper Yellow Pages Magazines Website Seminar

Other sources: _____

PATIENT EMPLOYMENT INFORMATION

Employer's Name: _____ Occupation: _____

Employer's Address: _____

Employer's Phone: _____ Ext: _____

IN CASE OF EMERGENCY

Please list name, phone number, and relationship of person to contact.

Name: _____ Phone: _____ Relationship: _____

Family Physician: _____ Phone: _____

Address: _____

Do you want copies of reports done here to be forwarded to your doctor? (Please circle) **Yes** **No**

I recognize and accept full financial responsibility for all professional services rendered, regardless of the amounts covered by any applicable insurance coverage. In the event Ernest B. Robinson, M.D., PC is required to collect your accounts after default, you will be responsible for all attorney fees and cost of collection. If insurance is to be filed, I authorize release of medical information including photographs necessary to process any claim for services provided by Ernest B. Robinson, M.D., PC.

Date: _____

Signature of Patient / Responsible Party

Relationship to Patient