WELCOME TO OUR OFFICE!

Thomas J. Montgomery, M.D, 1301 Camellia Blvd, Ste. 102, Lafayette, LA 70508

PATIENT REGISTRATION FORM

Patient's Name (Please Print)____
First Middle Last

Mailing Address___________________________City____________________ST_____Zip_________

Email Address ____Sex (Circle One) M F

Marital Status (Circle One) S M D W Sep Age: ________ Date of Birth____-____-______

Social Security Number ______-____-_______Home Telephone( )______-___________

Patient's Cellphone( )_____-_________ Parent/Legal Guardian Cellphone( )____-__________

Patient's Employer______________________________ Employer Telephone ( )____-__________

Please give a brief description of the reason for your Doctor Visit today:_________________________

If this is an Injury, Date of Injury________ If not an injury, Date when pain started:_________

PLEASE FILL OUT THE FOLLOWING BELOW THAT APPLIES.

Spouse's Name__________________DOB:___/___/______Social Security:. ______-______-______

Spouse's Employer______________________________ Employer's Phone No.( ) ______-_______

If patient is a minor(18 years of age or under) or if the insurance information is under the parent/guardian's name PLEASE provide the necessary information.

Mother's Name ________________________________ Social Security No. ______-______-______

Employer _____________________________________ Employer Phone _____________________

Father's Name ________________________________ Social Security No. ______-______-______

Employer _____________________________________ Employer Phone _____________________

IS THE PARENT OR GUARDIAN'S ADDRESS THE SAME ADDRESS AS THE PATIENT? Yes No

If NOT please provide the correct billing address below along with the responsible party.

NAME: _________________________________ RELATIONSHIP: ___________________________

ADDRESS ____ PHONE NO. ( )______-________

CITY, STATE, ZIP: ____

PLEASE READ: PLEASE PROVIDE RECEPTIONIST WITH A COPY OF YOUR INSURANCE CARD(S) ALONG WITH A COPY OF YOUR DRIVER'S LICENSE OR A PICTURE ID. All charges are due at time of service. If your insurance is a PPO, you will be responsible for either your copay or % after deductible has been met, or full amount if deductible has not been met. If this is workers compensation we will file your visits with your employer or compensation carrier as long as we have the necessary information.

PLEASE PROVIDE US WITH YOUR INSURANCE INFORMATION BELOW.

1st Insurance_______________________________ 2nd Insurance_________________________________

Policy Holder _____________DOB:___/___/_____ Policy Holder: ____________DOB:___/___/_____

Patient's Relationship to the Policy Holder Patient's Relationship to the Policy Holder

SELF SPOUSE CHILD SELF SPOUSE CHILD

Date Completed: ___________________________

Patient: ____

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR REASON FOR THIS VISIT.

1. In your own words please describe how you were injured and/or where the pain is coming from. Also include how long this pain or problem has been going on______________________________

____

2. Date of Injury ____/____/____ Were you injured on the job? (Circle One) Yes No

3. Was this a motor vehicle accident? (Circle One) Yes No Date of Accident____/____/____

If YES, name of the motor vehicle insurance? _____________________________________

ADDRESS ______________________________ CITY______________ST_____ZIP_______

PH# _______________________________ POLICY HOLDER:__________________________

AGENT: ____________________________POLICY NO. ______________________________

4. Have you seen any other physicians for this injury? (Circle One) Yes No

If so, please give name(s)____

5. Have you had any x-rays or other tests for this injury? (Circle One) Yes No

6. Do you have an attorney for this injury? (Circle One) Yes No

If so, please provide NAME:_____________________________PH#._____________________

ADDRESS ____

CITY _________________________________STATE__________ZIP____________________

NAME AND TELEPHONE NO. OF RELATIVE NOT LIVING WITH YOU:

Name:_______________________________________ **Telephone No. ( )_____-______**

RELATIONSHIP TO PATIENT: ____

**************AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS ******************

I hereby authorize Thomas J. Montgomery MD PC to release medical information necessary for claim reimbursement from Medicare, insurance companies, or other third parties to whom a claim may be submitted. I hereby assign payment of medical benefits to Thomas J. Montgomery MD PC**. I understand I am ultimately responsible for payment of all charges for medical services and if any claim to an insurance company or other third party is rejected, modified or not paid within 90 days, it is my responsibility to pay all charges in full. A 1.5 % per month rebilling charge is added after 90 days. If surgery is determined to be necessary, a *$300.00 prepayment* is required.** I authorize Thomas J. Montgomery MD PC to release medical records and reports to the referring physician or any other physicians or health care providers that may be consulted or who need access to these records for my medical care. I also authorize any other physician, laboratory, hospital or other provider to release all medical records and x-rays necessary for my care to Thomas J. Montgomery MD PC.

SIGNATURE_________________________________**DATE** _____________

IF THIS IS A WORKERS COMPENSATION INJURY, PLEASE READ AND SIGN BELOW.

*****************AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS*********************

I hereby authorize Thomas J. Montgomery MD PC to release medical records, x-rays, correspondence and any information regarding my medical treatment requested by my Employer and/or Workers Compensation Carrier.

SIGNATURE_________________________________**DATE** _____________