



**NEW PATIENT REGISTRATION**

_____ Patient Name (Last)	_____ (First)	_____ (MI)	_____ Date of Birth	_____ Age
_____ Address	_____ City	_____ State	_____ Zip	
_____ Home Telephone	_____ Cellphone	_____ Email		
_____ Patient's Employer	_____ Occupation	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
_____ Social Security #	Who may we thank for referring you: <input type="checkbox"/> Physician <input type="checkbox"/> Friend <input type="checkbox"/> Website <input type="checkbox"/> Other _____			
_____ Emergency Contact	_____ Relationship	_____ Address	_____ Telephone	
_____ Spouse's Name	_____ Date of Birth	_____ Social Security #		
_____ Spouse's Employer	_____ Occupation	_____ Address	_____ Telephone	

**INSURANCE INFORMATION**

_____ Name of Primary Insurance Carrier	_____ Group #	_____ Policy #	
_____ Insured's Name	_____ ID Number	_____ Effective Date	_____ Termination Date

**INSURANCE AUTHORIZATION, MEDICAL RECORD ASSIGNMENT, AND APPOINTMENT SCHEDULING**

It is your responsibility to understand the terms and requirements of your insurance plan. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Regarding insurance plans where we are a participating provider, you are responsible for supplying our staff with your current insurance card prior to seeing the doctor. If you do not have your card, you will be required to pay for the visit in full, at the time of service. Your co-pays and deductibles will, likewise, be due at the time of service. Please be aware that some of the services provided may not be covered by your medical insurance. You will be responsible for any remaining amount owed. In the event that we are not a participating provider with your insurance carrier, we require that you pay the balance in full at the time of the visit.

Regarding my medical records, I hereby authorize release of any medical information necessary to process any insurance claims with my insurance company and assign benefits to C. Scott Naylor, MD for all payments or medical services rendered to myself. I understand that I am responsible for all fees regardless of insurance coverage, and I understand that I am responsible for any deductibles, co-insurance, or amounts for services not covered by the insurance carrier. I further authorize release of all pertinent medical records to C. Scott Naylor, MD, Inc, necessary for diagnostic evaluation and continuing medical treatment.

Regarding my scheduled appointments, the office kindly asks for at least 24-hour advance notice to cancel or reschedule an appointment. I hereby acknowledge that any missed appointments, same day cancellations, or same day rescheduling will be subject to a \$30 charge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date