Dr. R. Garn Mabey Jr.
PATIENT REGISTRATION

Today's Date:			
PATIENT INFORMATION			
Last name: First:			Middle:
Social Security Number: / /		Birthdate:	
Marital Status: Single ☐ Married ☐			
Street address:			
P.O. box:	City:	State:	ZIP Code:
Home Phone no.:	Cell no.:		
Occupation:	Employer:	Work phone no.:	
Work Address:			
SPOUSE/PARENT INFORMATION			
Spouse/Parent Last name:	First:		Middle:
Birthdate:	Social Security Number: / /		
Employer:	Work phone:		Ext:
INSURANCE INFORMATION			
(Please give your insurance card to the receptionist when arriving at office.)			
Is this patient covered by insurance? ☐ Yes ☐ No			
Primary Insurance Company: ☐ [Insurance]			
Insured's Name:	Relationship to Patient :		
ID #:	Group #:		
Claim's address:			
Secondary Insurance Company: ☐ [Insurance]			
Insured's Name:	Relationship to Patient:		
ID #:	Group #:		
Claims Address:			
IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):			
Cell phone no.:	Work phone no.:	Relationship to patient:	
NOTICE TO ALL PATIENTS (Please Read and Sign)			

I, the undersigned, agree to assign all benefits payable to me to R. Garn Mabey, JR., M.D. for services rendered. I understand that I am responsible for any deductibles, copays, and non-covered charges as dictated by my insurance carrier, and any balance over 120 days old. I hereby authorize Dr. Mabey to release any and all information necessary to assist in my treatment and secure payment of my claims, including but not limited to medical records, insurance cards, etc. I authorize the use of this signature for all claims and releases required. Should my insurance company fail or be unable to pay for any of my services, I acknowledge that I am responsible for paying any balance due. A copy of the Notice of Privacy Practices was made available to me.

Signature: Date: