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MARK L. THORNTON, MD, FACP / EXECUDOC, INC.

PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information.
Please print or type. All information will be strictly confidential.

Patient's Name (Last, First):	Sex: F M	Date of Birth: / /	Age:
Residence Address:	City:	State:	Zip:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	
Patient Social Security #: - -	Email Address::		
Person Financially Responsible for this Account (Last, First):	Self Spouse Parent		
Responsible Party's Birthday: / /	Responsible Party's Social Security #: - -		
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	
Email Address:			
Emergency Contact:	Relationship:	Contact Phone: ( )	

PRIMARY INSURANCE INFORMATION

Type of Insurance: Self Pay ☐ PPO ☐ HMO ☐ Medicare ☐			
Primary Insurance:	Policy #:	Group #:	Effective Date:
Subscriber Name (Last, First):			
Subscriber Birth Date: / /	Subscriber Social Security #: - -		

SECONDARY INSURANCE INFORMATION

Type of Insurance: Self Pay ☐ PPO ☐ HMO ☐ Medicare ☐			
Primary Insurance:	Policy #:	Group #:	Effective Date:
Subscriber Name (Last, First):			
Subscriber Birth Date: / /	Subscriber Social Security #: - -		

CREDIT CARD INFORMATION

MasterCard ☐ Visa ☐ American Express ☐ Discover ☐		
Name on Card:	Credit Card #:	Exp. Date: