ROBERT D. MIXSON, M.D., P.A.

PLEASE PRINT CLEARLY

**** Cell Phone:** _____

Name: _____ **Nickname:** _____

Address: _____
City State Zip Code

Home Phone: _____ Date of Birth: ____ / ____ / ____ Age: _____ Social Security#: _____

Marital Status: _____ Referring Physician or Patient: _____

Email Address: _____

Patient's Occupation: _____ Employer: _____

Work Phone: _____

Spouse's Name: _____ Spouse's Social Security #: _____

Nearest Emergency Contact: _____ Phone: _____

Primary Care Physician: _____

PREFERRED PHARMACY: _____

INSURANCE INFORMATION Subscriber's Date of Birth: : _____ / _____ / _____ Age: _____

Primary Insurance: _____ Subscriber's Name: _____

Policy/ID# : _____ Group#: _____ Subscriber Relationship:_____

Secondary Insurance: _____ Subscriber's Name: _____

Policy/ID# : _____ Group#: _____ Subscriber Relationship:_____

TRICARE patients Please check correct plan:

PRIME _____ EXTRA _____ SELECT _____

Subscriber's Date of Birth: : _____ / _____ / _____ Age: _____

Per government regulations you must complete BOTH items below:

RACE (circle one)		**ETHNICITY (circle one)**
American Indian / Alaska Native	Declined	Declined
Asian	Other Race	Hispanic/Latino
Black/African American	White	Not Hispanic/Latino
Nat Hawaiian/Pacific Islander		

LIFETIME AUTHORIZATION:

I authorize the above named physician to release any information to my insurance company needed to process a claim. I request that payment of authorized benefits be made on my behalf to the above physician. I understand that I am responsible for any uninsured portion not paid by my insurance company and responsible for all collection and legal fees. A copy of this authorization may be used in lieu of the original.

Signature: _____ Date: _____