

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

PLEASE PRINT CLEARLY

Chart #: _____

**** 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: _____

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

Nearest Emergency Contact: _____ Phone: _____

Primary Care Physician: _____

LOCAL PHARMACY NAME: _____

INSURANCE INFORMATION

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

Primary Insurance: _____ Subscriber's Name: _____

Policy/ID# : _____ Group#: _____ Effective Date: _____

TRICARE patients Please check correct plan:

PRIME _____ EXTRA _____ STANDARD _____

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

Secondary Insurance: _____ Subscriber's Name: _____

Policy/ID# : _____ Group#: _____ Effective Date: _____

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: _____