

James W. Douglas, M.D.

New Patient Registration

Please print this page, fill out the form and fax it to (972) 612-9601.

ABOUT THE PATIENT:	ABOUT THE SPOUSE:
Last name: _____	Last name: _____
First name: _____	First name: _____
SSN # _____	SSN # _____
DOB: _____	DOB: _____
Sex: M or F	Sex: M or F
To be addressed as: _____	To be addressed as: _____
Street address: _____	Street address: _____
City: _____	City: _____
State: _____ Zip: _____	State: _____ Zip: _____
Home # _____	Home # _____
Work # _____	Work # _____
Cell # _____	Cell # _____
Employer: _____	Employer: _____
Referred by: _____	Referred by: _____
DL # _____	DL # _____
Nearest relative: _____	Nearest relative: _____
Phone # _____	Phone # _____

In order to control your cost of billings, our charges for office visits are to be paid at the time of service. You will be paying by: <input type="checkbox"/> check <input type="checkbox"/> cash <input type="checkbox"/> charge.	
Are you covered by: Medicare Y/N	Medicaid Y/N
Medical Insurance: Y/N	Through your work: Y/N
Primary: _____	
Name of Insurance: _____	Group # _____
Address: _____	ID # _____
_____	Ins. Phone # _____

I am legally responsible for payment of my bills made by myself or my dependents for medical care for Dr. James Douglas M.D.	
Signed: _____	Date: _____
Name of responsible party: _____	