DAVID B. MCALPINE, M.D., F.R.C.O.G.

PATIENT'S NAME ______________________________
LAST FIRST MI

ADDRESS ______________________________ APT # __________

CITY ____________________ STATE __________ ZIP __________

HOME TELEPHONE NUMBER __________________ CELL PHONE NUMBER __________________

SOCIAL SECURITY # __________________ DATE OF BIRTH __________________ AGE ________

☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOW

EMAIL: ______________________________

EMPLOYER __________________ OCCUPATION __________________

TELEPHONE NUMBER __________________ EXTENSION __________________

EMERGENCY CONTACT __________________ RELATIONSHIP __________________

PHONE NUMBER __________________

REFERRED BY ______________________________

SPOUSE/GUARDIAN ______________________________
LAST FIRST MI

ADDRESS ______________________________
CITY STATE ZIP

HOME TELEPHONE NUMBER __________________ CELL PHONE NUMBER __________________

SOCIAL SECURITY # __________________ DATE OF BIRTH __________________

EMPLOYER __________________ TELEPHONE NUMBER __________________

INSURANCE INFORMATION

PRIMARY INSURANCE __________________ ID# __________________

INSURED'S NAME __________________ DATE OF BIRTH: __________________

RELATIONSHIP TO PATIENT: __________________

SECONDARY INSURANCE __________________ ID# __________________

INSURED'S NAME __________________ RELATIONSHIP TO PATIENT __________________

ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. I ALSO CONSENT FOR DR. MCALPINE TO TREAT ME.

PATIENT/GUARDIAN SIGNATURE ______________________________ DATE __________________

PLEASE NOTE: PAYMENT IS DUE AT THE TIME OF SERVICE. OUR OFFICE DOES ACCEPT VISA, MASTERCARD, DISCOVER, CHECKS AND CASH. WE ARE PROVIDERS FOR MOST HMO'S AND PPO'S. PLEASE GIVE CARD TO RECEPTIONIST FOR PROPER BILLING AND TO AVOID PAYMENT DELAY.