

Full name:		Birth date:	Gender:
Preferred name or nickname?			
Mailing address (include city, state, and zip):			
Street address (if different than mailing):			
Home phone:		Social Security Number:	
OK to leave a message on home voice mail? Yes No		Please tell us if you are in a committed relationship:	
Work phone:		May we know your spouse's or partner's name?	
OK to leave a message on work voice mail? Yes No		Have you signed a Directive to Physicians?	
Mobile phone:		Have you signed a Health Care Power of Attorney?	
OK to leave a message on mobile voice mail? Yes No		Whom do you want us to contact in case of emergency?	
Email address:		What is the best way to reach them?	
OK to send message to your email? Yes No		Emergency Contact address if different than yours:	

Mail order pharmacy name:	Local pharmacy name:
Mail order pharmacy address/city/state/zip:	Local pharmacy address/zip:
Mail order pharmacy phone:	Local pharmacy phone:
Mail order pharmacy FAX:	Local pharmacy FAX:

Although full payment is required at the time you receive services, we keep your insurance information on file to make it easier when we order x-rays or when we refer you to another physician.

(Please continue to next page)

Primary Insurance:	Subscriber Name:
Address:	Subscriber ID:
Phone Number:	Date Of Birth:
Group Name:	Group Number:

Secondary Insurance:	Subscriber Name:
Address:	Subscriber ID:
Phone Number:	Date Of Birth:
Medigap? Supplemental?	Group Number:

Records Release

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. In case any services are provided to me but not paid in full at the time of service (for example, emergency or hospital-based services), I hereby assign to Gary W. Brewton, M.D. all payments from my insurance or any other third party payor for the medical services provided. I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

Credit Card Authorization

I hereby authorize Gary W. Brewton, M.D., to charge my credit card account for any services that are provided including a fee of \$75 if I fail to cancel any appointment with the doctor at least one working day in advance. I understand that this credit card will not be charged more than once a month and I will receive a statement of the charges and a receipt of payment in the mail. If there is any change in my credit card number I agree to notify Dr. Brewton promptly. This authorization does not change my obligation to pay in full amounts due at the time services are provided.

Card type: VISA MasterCard American Express Discover

Credit Card Number: _____

Expiration Date: _____ CVV/CCID/Card Security Code: _____

Name on Card: _____

Billing Address: _____

City, State, Zip: _____

Signature: _____ Date: _____