LAMAR ROBINSON, M.D., P.A.
1929 RECORD CROSSING ROAD | DALLAS, TX 75235 | 214-905-9090

PATIENT REGISTRATION

Date _____ /_____ /_____

Name:_____ Age:_____
Last **First** **Middle**

DOB _____ /_____ /_____ Social Security # _____ - _____ - _____

Address _____ Apt #_____
City _____ State _____ Zip Code _____
Telephone (_____)_____ - _____ TX DL # _____

Employer_____ Occupation _____
Employer Address _____
City _____ State _____ Zip Code _____
Telephone (_____) _____ - _____ Ext. _____

Spouse's Name_____ DOB _____ /_____ /_____
Spouse's Employer _____ Occupation _____
Telephone (_____) _____ - _____ Ext. _____

Referred By:_____

ASSIGNMENT OF BENEFITS

Payment is expected at the time services are provided unless prior arrangements have been made. All insurance claims processed by this office, prior to payment in full, are assigned to this office. I authorize payment of medical and/or surgical benefits to Lamar Robinson, M.D., P.A. for services provided. I also authorize the release of any medical or other information necessary to process this insurance claim.

To further ensure patient confidentiality, please create a secret password or codeword **that you will remember!** You **must** provide your password, name, DOB, SSN if you request the release of your records.

Signed: _____ Password: _____
Hint: mother's maiden name; favorite pet; lucky numbers; city of birth; hobby

Insurance Co. _____ Phone (_____) _____ - _____
Insured Name_____ Social Security # _____ - _____ - _____
Insured DOB _____ / _____ / _____ Policy or Group # _____

STATEMENT OF FINANCIAL RESPONSIBILITY

I realize that all medical and/or surgical charges incurred by me and/or my dependents for services provided by Lamar Robinson, M.D., P.A. are my financial responsibility. In the event insurance is denied, I understand full payment is my responsibility.

Signed_____ Date _____ / _____ / _____

PLEASE NOTE: THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY THAT WILL BE KEPT IN THIS OFFICE.