GREGORY C. MAYS
M.D., PLC
(540) 962-2020

1802 Midland Trail
Covington, VA 24426
www.gregorymaysmd.com

Patient Registration Form

Patient Information

Last Name__________________________________ Sex (circle one) M F
First Name__________________________________
Middle Name_________________________________
SS#_____________________________Birthdate________/_______/__________
Address________________________________ City_________________________
State_________ Zip_________________ Race_____________________________
Contact #__(______)_____________ Email _____________________@_________

Responsible Party (if other than patient)

Last Name______________________ First Name__________________ M.I.____
Address__________________________ City___________________ State_______
Zip______________________ Contact #__(______)_________________________
Occupation___________________ Place of Employment____________________
Date of Birth _______/_______/__________

Primary Doctor:____________________________________

How did you find out about our office?

Doctor Referral ____
Word of Mouth ____
Newspaper ____
Facebook ____
Google Search ____
Other:_________________________________

I have been presented with a copy of the provider's Notice of Privacy Policies and understand how my information may be used and disclosed as permitted by law.

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Patient Signature **Date**

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Lifetime Signature Agreement

I request payment of Medicare, Champus, and/or health insurance benefits be made on my behalf to Gregory C. Mays M.D., PLC for services provided to me. I authorize any holder of medical information about me to release to the healthcare financing administration and its agents or other insurance carriers or agencies and theirs agents, any information needed to determine these benefits payable for related service. Regardless of my health insurance coverage, I understand I will be responsible for paying all medical services.

______________________________ ______________________________

Signature **Date**