James C. Wasson, M.D., P.C.

Registration Form

Please fill this form out completely. We will be unable to file your insurance claim without all of this information.

Patient_____ Age_____ Date of Birth_____
First Name Middle Initial Last Name

Address_____
Street City/State Zip

Primary Phone _____Secondary Phone _____Work Phone_____

Email address_____ ☐ Decline to provide email

SS# _____-_____-_____ Gender: ☐ Male ☐ Female

Race/Ethnicity: _____☐ Decline Language preference_____

Special Needs (i.e.. hearing, vision, mobility)_____☐ None

Emergency Contact_____
Name Relationship Phone Number

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated **Military?** ☐ Active ☐ Retired

If married, spouse's name_____

Children's names and ages_____

Legal Guardian_____ Caregiver_____☐ N/A

Patient Employer _____**Insured Employer**_____

Primary Insurance Company_____ ☐ HMO ☐ PPO ☐ Other

Policy Number_____GroupNumber_____

Policy Holder: ☐ Self ☐ Spouse ☐ Parent **If policy holder is spouse or parent, we need the following:**

Name _____SS#_____-____-_____ Date of Birth_____

Secondary Insurance Company_____☐ HMO ☐ PPO ☐ Other

Policy Number _____Group Number_____

Policy Holder: ☐ Self ☐ Spouse ☐ Parent **If policy holder is spouse or parent, we need the following:**

Name _____SS#_____-____-_____ Date of Birth_____

New Patient: How did you hear about us? _____