STANLEY J WATERS, MD, PhD
REGISTRATION FORM

(Please Print)

Today's date:	Primary Care Physician:
Preferred Pharmacy:	Referring Physician:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	Race: (please circle one) American-Indian, Asian, White, Pacific Islander, African American , Hispanic, Other:_____	Ethnicity:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Address:	Social Security #:	Home phone #: Cell Phone #:		
City:	State:	Zip:		
Employer:	Employer Phone #: ( )			

IF PATIENT IS A MINOR

Mother's Name:	Father's Name:	Mother's DOB: Mother's SS #:	Father's DOB: Father' SS#:
Address:	City:	State:	ZIP Code:

OTHER INFORMATION

Information may be released to: ❑Spouse ❑Parent ❑Children ❑Other:

INSURANCE INFORMATION

(Please give your insurance card and photo ID to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone #: ( )
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	Employer:	Employer address:	Employer phone # : ( )
Is this patient covered by insurance? ❑ Yes ❑ No	Insurance Carrier:		

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize the office of Dr. Waters or my insurance company to release any information acquired in the course of my examinations or treatment which is necessary to process my claims. I also recognize and accept personal responsibility for any fee accrued for his service, and assign all benefits due to me to be paid directly to Stanley J Waters, MD, PhD. CONSENT FOR TREATMENT: I am presenting myself for patient care with Dr. Waters and I voluntarily consent to the rendering of such care including diagnostic procedures and medical treatment by the doctor and his medical staff or their designees as in their professional judgement may be deemed necessary. I acknowledge that no guarantees have been made to me as the result of examination or treatment in this facility.

Patient/Guardian signature ***Date***