DocTalker Family Medicine Registration Form

Patient Information

Name: ____
Date of Birth (DOB): __________________ Sex: Female Male
Street Address: ____
City: ______________________________________ State: _______ Zip: _________________
Home Phone: _____________________ Work Phone: _________________________
Cell Phone: _______________________ Fax: _______________________________
Primary E-mail:____
Second E-mail: ____

Emergency Contact Information

Name: ____
Relationship to Patient: __________________________ Home Phone: ___________________________
Cell or Work Phone: ________________________ E-mail: ____

Responsible Party for Billing (If different than patient)

Name: ____
Street Address: ____
City: __________________________________ State: ________ Zip: ____________________
Relationship to Patient: _____________________________ Home Phone: ___________________________
Cell or Work Phone: _______________________ E-mail: ____

Insurance

DocTalker does not participate directly with insurance, Medicare or Medicaid. Upon request DocTalker will provide the necessary forms to submit to insurance but it is the patient's full responsibility to submit for reimbursement. Secondary Services ordered on the patient's behalf may be covered by insurance. For this purpose we ask you to provide insurance and or Medicare information.

Primary Insurance in Whose Name ____ Date of Birth __________
Primary Insurance Carrier ____________________________________ Telephone ______________________
Group Number _______________________________ Policy ID Number _______________________________
Secondary Insurance in Whose Name ______________________________________ Date of Birth __________
Secondary Insurance Carrier___________________________________ Telephone ______________________
Group Number _______________________________ Policy ID Number _______________________________

How did you hear about DocTalker? ___________________________________

(must have Adobe Reader)
or send to info@doctalker.com