William M. Brown
1789 N. Keyser Avenue
Scranton, PA 18508

Patient Registration Form

Name:_____ Prefer to be called_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:(___)_____ Work Ph:(___)_____ Cell:(___)_____

Email Address:_____@_____

Date of Birth:_____/_____/_____ Social Security Number:_____ ____ _____

Family Physician:_____ Date of last visit:_____

Employer:_____

Spouse or Parent name if a minor:_____

Emergency Contact:_____ Phone Number:(____)_____

How did you hear about us? Google/Internet___ Friends/Family___ Doctor Referral_____
Insurance ___ Facebook___ Other_____

Insurance Information

Please be sure to bring a copy of your insurance card or cards to your first appointment along with a driver's license or photo ID.

Insurer Name:_____ ID#_____Group #_____

Subscriber:_____ Date of Birth:_____ SSN:_____

Relationship to Patient: __ Self __ Spouse __ Parent __Other _____

Secondary Insurer:_____ ID#:_____

Authorization

I hereby authorize the release of medical or other information necessary to process insurance claims. I authorize payment of insured's benefits to Dr. William M. Brown.

Signed:_____ Date:_____