Timothy J. Mickel M.D., F.A.C.S.

Timothy J. Mickel, M.D., F.A.C.S.
903 North 2nd. Street
Monroe, LA 71201
(318) 388-2050

Date _____
ACCT# _____
REFERRED BY: _____

Patient Registration Form

GENERAL

(Please Print Clearly)

Name You Go By: _____

PATIENT'S FULL NAME _____ *First Name* _____ *M.I.* _____ *Last*

(If Minor, Parent's Name) _____ *First Name* _____ *M.I.* _____ *Last*

PATIENT'S SOCIAL SECURITY# _____ DATE OF BIRTH _____ (MM/DD/YY) AGE _____

EMAIL ADDRESS:

SEX: *(Select One)* Male ☐ Female ☐

MARITAL STATUS *(Select One)* Married ☐ Single ☐ Divorced ☐ Widowed ☐

PHONE *Home* ( ) _____ *Driver's License #* _____

Cell ( ) _____ *State* _____

HOME ADDRESS: _____ *Number* *Street* *Apt. #*

_____ *City* *State* *Zip*

OCCUPATION: _____ *(patient)* ☐ *(parent)* ☐

EMPLOYER: _____ *(patient)* ☐ *(parent)* ☐

EMPLOYER'S ADDRESS: _____ *(patient)* ☐ *(parent)* ☐

EMPLOYER'S PHONE: ( ) _____ *(patient)* ☐ *(parent)* ☐

SPOUSE'S/PARENT'S NAME: _____ *First Name* *Maiden/Middle* *Last*

SPOUSE'S/PARENT'S EMPLOYER *(Name, Address/Phone Number)* _____

Date of Birth: *(spouse)* ☐ *(mother)* ☐ *(father)* ☐ _____

Social Security #: *(spouse)* ☐ *(mother)* ☐ *(father)* ☐ _____

Nearest Relative *(not at your address)*

Name _____ *Relationship* _____

Address _____ *Telephone* _____

INSURANCE

INSURANCE CARRIER: _____ *Policy #* _____

Address to send claim: _____ *Group #* _____

INSURED'S NAME: _____ PATIENT RELATIONSHIP TO INSURED *(select one)*

(Self) ☐ *(Spouse)* ☐ *(Child)* ☐ *(Other)* ☐

SECONDARY CARRIER: _____

INSURED'S NAME: _____ *Policy #* _____ *Group #* _____

Address to send claim: _____