REGISTRATION

Ryan Crenshaw, M.D Date: _____

Last Name _____ First Name _____ M.I. ____ Sex: M ___ F ___
Social Security # _____ (Confidential; for billing purposes only) DOB_____ Marital status: S M W D

Street Address: _____ City: _____ State: _____ Zip: _____
Please check preferred method of appointment confirmation below:
□ Home Phone#: _____ □ Cell Phone#: _____ □ Work phone#: _____
Employer: _____ Occupation: _____ May we call your place of employment? Y N
Email: _____
Pharmacy Name: _____ City: _____ Phone: _____

Primary Care Provider's Name/Address/Phone: _____
Referring Provider's Name/Address/Phone (if different than PCP): _____

Language: English: ___ Other: ___ **Ethnicity**: Hispanic ___ Non-Hispanic ___
Race: White ___ Black/African American ___ Asian ___ American Indian/Alaska Native ___
Native Hawaiian/Other Pacific Islander ___ Decline response ___

PRIMARY INSURANCE INFORMATION
Insurance Co. Name: _____ Policy #: _____ Group #:_____
Policy holder's Name: _____ Relationship to Patient: _____
Policy holder's Social Security # _____ DOB_____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone#: _____Work Phone#: _____ Cell phone#:_____

SECONDARY INSURANCE INFORMATION
Insurance Co. Name: _____ Policy #: _____ Group #:_____
Policy holder's Name: _____ Relationship to Patient: _____
Policy holder's Social Security # _____ DOB_____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone#: _____Work Phone#: _____ Cell phone#:_____

Person(s) you would like to authorize to receive/discuss medical information: _____
Person to contact in case of an emergency: _____ Relationship/phone#: _____

Assignment and Release of Information
I the undersigned have insurance coverage with _____and assign directly to Dr. Ryan Crenshaw all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, as well as fees of 30% if this account is sent to collections. There will be an interest rate of 18% APR on all overdue balances. I hereby, authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian: _____ Date: _____

I hereby authorize Ryan Crenshaw, MD, PC to apply for benefits on my behalf for services rendered and authorize the release of any information acquired in the course of my treatment necessary to process insurance claims. I request payment from the above indicated insurance carrier to be made directly to Ryan Crenshaw, MD, PC, realizing that I am responsible for all non-covered charges. I also realize I am responsible for any other costs incurred while collecting my outstanding balance(s). I acknowledge their notice of privacy practices is available to me upon request. I certify that the information I have reported is correct to the best of my knowledge. This is to remain in effect indefinitely unless revoked in writing by the undersigned.

Patient, Parent or Guardian Signature: _____ Date: _____