Dr Summers W Taylor III
OBGYN

Chart #: ____________ Todays Date: ____________

Last Name: ____________ First Name: ____________ Middle Initial: ________

Address: ____

City: ____________ State: ____________ Zip Code: ____________

Home Phone #: ____________ Cell Phone #: ____________ Work #: ____________

Driver License #: ____________ Birthday: ____________ Soc. Sec #: ____________

Language: ____________ Race: ____________

Employer: ____________ Occupation: ____________ Phone#: ____________

Marital Status: ____________ Spouse Name: ____________

Emergency Contact Name: ____________ Phone#: ____________

Emergency Contact Name: ____________ Phone#: ____________

PRIMARY INSURANCE: ____ Self ____ Spouse ____ Parent ____ Other

Plan Name: ____________ Insured Name: ____________

Insured's Date of Birth: ____________ Insured's Soc Sec #: ____________

Policy #: ____________ Group#: ____________ Eff Date: ____________

SECONDARY INSURANCE: ____ Self ____ Spouse ____ Parent ____ Other

Plan Name: ____________ Insured Name: ____________

Insured's Date of Birth: ____________ Insured's Soc Sec #: ____________

Policy #: ____________ Group#: ____________ Eff Date: ____________

****

The above information is true to the best if my knowledge. I authorize my insurance benefits to be paid directily to the physician. I understand that I an financially responsible for any balance left on my account. I authorise DR TAYLOR, at 2505 US HWY 431, Womens Center Suite A, Boaz, AL 35957 or the insurance company to release any information required to process my claims.

Signature: ____________________________ Date: ____________