☐ **KRAIG C. MCGEE, M.D.**
☐ **ALAN MIRLY, PA-C**

☐ **DAVID R. DONALDSON, M.D.**
☐ **JESSICA REDDING, PA-C**

PATIENT REGISTRATION FORM

(Please Print Clearly)

Referring Doctor:	**Primary Doctor:**

PATIENT INFORMATION

Last Name:	First:	Middle:	**Marital status** Single / Married / Divorced/ Separated / Widow

Is this your legal name? **YES** or **NO**	If not, what is your legal name?	What is your former or Maiden Name?	**Date of Birth**: _____/_____/_____	**Gender**: Male Female Other

Mailing address: (Please list PO Box if this is where mail is received)	City:	State:	Zip Code:

Cell Phone Number:	Home Phone Number:	Social Security Number:
Employer:	Employer Phone No: ( )	**Pharmacy Name/City/State:**

Our office has Electronic Medical Records (EMR) Providing your email address will give you access to your account and records online.

Email address:	Consent to check external medication list? **YES** or **NO**

INSURANCE INFORMATION

Primary Insurance Company:	Policy Number:	Group number:

Subscribers Name:	Date of Birth: _____/_____/	Relationship to patient: ***Self / Spouse / Mother / Father / Other***

Secondary Insurance Company:	Policy Number:	Group number:

Subscribers Name:	Date of Birth / /	Relationship to patient: ***Self / Spouse / Mother / Father / Other***

IN CASE OF EMERGENCY

Emergency Contact Name:	Phone Number:

If patient is a MINOR List Parent(s) or Legal Guardian	Mother's Name: _____ Father's Name: _____	Mother's Date of Birth: _____/_____/_____ Father's Date of Birth: _____/_____/_____

ADVANCE DIRECTIVE

Advance Directive is a document by which a person makes provision for health care decisions in the event that, in the future, he/she becomes unable to make those decisions. The two main types are "Living Will" and "Durable Power of Attorney for Health Care".

Do you have an **Advance Directive?** ***YES*** or ***NO***	Name of person(s) on Advance Directive: 1) _____ 2) _____	Phone number for Advance Directive: 1) ( ) _____ 2) ( ) _____	Relationship: 1) Spouse / Parent / Child / _____ 2) Spouse / Parent / Child / _____

Written Acknowledgement for the Receipt of the Notice of Privacy Practices: (HIPPA)
I (patient/representative) have been informed of Kraig C. McGee, M.D. and David R. Donaldson, M.D. Notice of Privacy Practices.
I also understand a copy is available to me upon request.

Would you like a copy? ☐ **YES** ☐ **NO**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Kraig C. McGee, M.D. and/or David R. Donaldson, M.D. or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature ***Today's Date***