Troy K. Richey MD PC

Christy S. McAllister PA-C

This section must be completed for all patients: Today's Date ___/___/___

Name _____
First Middle Last

Date of Birth:___/___/___ Age:___ SS #_____ Sex: ❑Male ❑Female

Address:

Mailing Address _____
City State Zip

Home Phone: ( )_____ Work Phone: ( )_____

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated ❑Other

Referred by: _____

Parent, Spouse, or Responsible Party (if different from patient):

Name _____ Date of Birth:___/___/___
First Last M.I.

Address _____
City State Zip

Home Phone: ( )_____ Work Phone: ( )_____

May we call you at work? ❑Yes ❑No

May we leave a message on your answering machine? ❑Yes ❑ No

Attach a copy of patient's insurance card (both sides)

Insurance Coverage- Primary:

Insurance Co. Name:_____ Phone: ( )_____ Ext:_____

Address of Claim Center: _____

Name Policy Holder (Insured):_____

Insured Date of Birth:_____/_____/_____ Sex: ❑Male ❑Female

Policy/ID# _____ Group Name or # _____

Employer Name _____

If patient is child check relationship: ❑Mother ❑Father ❑Other _____

Insurance Coverage- Secondary:

Insurance Co. Name:_____ Phone: ( )_____ Ext:_____

Address of Claim Center: _____

Name Policy Holder (Insured):_____

Insured Date of Birth:_____/_____/_____ Sex: ❑Male ❑Female

Policy/ID# _____ Group Name or # _____

If patient is child check relationship: ❑Mother ❑Father ❑Other _____