Dr. Elizabeth M Weaver, MD
Patient Registration Form Appointment Date:

Patient Information:

Name: _____ DOB: _____
SS#: _____ ☐ Male ☐ Female
Address: _____
City:_____State:_____ ZIP:_____

Home Phone:_____ Cell Phone:_____
Email Address:_____
May we send you a link to our patient portal: ☐ yes ☐ no
Contact preference: ☐ Home ☐ Cell ☐ email/portal ☐paper mail

Preferred Pharmacy:_____ Location:_____

Employer:_____Work Phone:_____
Or ☐Unemployed ☐ Disabled ☐ Student ☐Retired

Race: ☐ White/ Caucasian ☐African American ☐Hispanic/Latino ☐Native American
☐ Asian ☐ Middle Eastern ☐ Declined
Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Declined
Language: ☐ English ☐ Spanish ☐ Other _____

Relationship Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Emergency Contact Information:
Name: _____Relationship: ☐ Spouse ☐ Parent ☐Other
Home Phone:_____Cell Phone:_____

Guarantor Information/Insurance Policy Holder:
Relationship to Patient: ☐Self ☐ Spouse ☐Parent
Name:_____ DOB:_____
Address:_____
City:_____State:_____ ZIP:_____
SS#:_____

Authorized payment policy/ Cancellation Policy:
I hereby authorize Dr. Elizabeth M Weaver, MD to release my treatment information as necessary to process insurance claims, and that payment of medical benefits (if any) go directly to the Provider. I am responsible for paying non-covered services, deductible, and co-insurance amounts.
I understand that there is a $50.00 late-cancellation/no-show fee if I fail to provide the necessary 24 hour notice of cancellation.

_____
Patient/Legal guardian signature Date