Dr. James Webb & Associates

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James R. Webb, Jr. M.D. **Amanda Robison, A.P.R.N. C.N.P.**

Patient Information Form

Name:_____ Date of Birth:_____ Sex: M F

Home Phone:_____ Cell:_____ Work:_____

Social Security #:_____ Email Address:_____

Home Address:_____ City:_____ Zip Code:_____

Driver's License Number:_____ State:_____ Exp. Date:_____

Race (Check One): __Caucasian __African American __ Hispanic __ Native Indian __Asian

Spouse's Name:_____ Phone:_____ Date of Birth:_____

Emergency Contact:_____ Relation:_____ Phone:_____

Primary Care Physician:_____ Phone:_____

Whom may we thank for referring you to us?_____ Phone:_____

Employer Information

Employer Name:_____ Phone:_____

Insurance Information

Insurance Company:_____ ID#_____Group #_____

Name of Insured:_____ Relationship to Patient:_____

Birthdate:_____ Social Security Number:_____

Do you have Secondary Insurance? __Yes __No

Insurance Company:_____ ID#_____Group #_____

Name of Insured:_____ Relationship to Patient:_____

Birthdate:_____ Social Security Number:_____

I will promptly disclose any necessary information to my insurance carrier necessary to resolve any issues they may have. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. By signing this form I authorize James R. Webb, Jr., MD., P.C. to release my protected health information to the emergency contact listed above. I will notify you of any changes in my status or the above information.

_____ _____

Signature Date