

WILLIAM J. FLYNN, M.D.P.A.
2211 HARRISON AVE
PANAMA CITY, FL 32405
TEL: (850) 763-2555
FAX: (850) 763-9374

**WE DO NOT BILL
SECONDARY INSURANCE**

**REGISTRATION INFORMATION
(PLEASE PRINT)**

DATE: _____ HOME PHONE: _____

PATIENT: _____
LAST NAME FIRST NAME MIDDLE INITIAL

RESPONSIBLE PARTY (IF A MINOR): _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SEX: M ___ F ___ BIRTHDATE _____ AGE ___ SINGLE ___ MARRIED ___ WIDOWED ___ DIVORCED ___

PATIENT EMPLOYED BY: _____

BUSINESS ADDRESS: _____

OCCUPATION: _____ BUSINESS PHONE: _____

PURPOSE OF VISIT: _____

PATIENT SOCIAL SECURITY NO.: _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT: _____ RELATIONSHIP TO PATIENT _____

SPOUSE'S SOCIAL SECURITY NO.: _____ SPOUSE'S DATE OF BIRTH: _____

DO YOU HAVE MEDICAL INSURANCE? NO ___ YES ___

NAME OF PRIMARY INSURANCE: _____

NAME OF POLICY HOLDER: _____ POLICY # _____ GROUP # _____

NAME OF SECONDARY INSURANCE: _____

NAME OF POLICY HOLDER: _____ POLICY # _____ GROUP # _____

ALLERGIES: _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? _____ PHONE: _____

YOUR DRUG STORE NAME: _____

HOW DID YOU LEARN OF OUR PRACTICE? _____

ASSIGNMENT OF INSURANCE BENEFITS

THE UNDERSIGNED HEREBY AUTHORIZES THE RELEASE OF ANY INFORMATION TO ALL CLAIMS FOR BENEFITS SUBMITTED ON BEHALF OF MYSELF AND/OR DEPENDENTS. I FURTHER EXPRESSLY AGREE AND ACKNOWLEDGE THAT MY SIGNATURE ON THIS DOCUMENT AUTHORIZES MY PHYSICIAN TO SUBMIT CLAIMS SUBMITTED FOR BENEFITS, FOR SERVICES RENDERED OR FOR SERVICES TO BE RENDERED, WITHOUT OBTAINING MY SIGNATURE ON EACH AND EVERY CLAIM TO BE SUBMITTED FOR MYSELF AND/OR DEPENDENTS, AND THAT I WILL BE BOUND BY THIS SIGNATURE AS THROUGH THE UNDERSIGNED HAD PERSONALLY SIGNED THE PARTICULAR CLAIM.

I _____ HEREBY AUTHORIZE _____
(NAME OF INSURED) (NAME OF INSURANCE COMPANY)

TO PAY AND HEREBY ASSIGN DIRECTLY TO WILLIAM J. FLYNN, M.D. ALL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS/HER SERVICES AS DESCRIBED ON THE ATTACHED FORMS. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED. I FURTHER ACKNOWLEDGE THAT ANY INSURANCE BENEFITS, WHEN RECEIVED BY AND PAID TO DR. WILLIAM J. FLYNN, M.D. WILL BE CREDITED TO MY ACCOUNT IN ACCORDANCE WITH THE ABOVE ASSIGNMENT.

(AUTHORIZED SIGNATURE OF SUBSCRIBER)

(DATE)