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)**

PATIENT INFORMATION SHEET

NAME:_____GENDER:____DOB:_____DATE:_____

ALLERGIES:_____

LIST ALL MEDICATIONS YOU TAKE, INCLUDING OVER-THE-COUNTER AND VITAMINS

INCLUDE SPECIFIC DOSES & WHEN TAKEN. IF YOU DON'T KNOW CALL YOUR PHARMACY.

_____

_____

_____

_____

_____

PERSONAL MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

ADHD	COPD/EMPHYSEMA	HIGH CHOLESTEROL	RHEUMATOID ARHTRITIS
ALCOHOLISM	DEMENTIA	HIV	SEIZURE DISORDER
ALLERGIES	DEPRESSION	HEPATITIS	SLEEP APNEA
ANEMIA	DIABETES:1 OR 2	IRRITABLE BOWEL SYN.	STROKE
ANXIETY	DIVERTICULITIS	LUPUS	THYROID DISORDER
IRREGULAR HEART BEAT		BLOOD CLOT	LIVER DISEASE
ARTHRITIS	ACID REFLUX	MACULAR DEGENERATION	ASTHMA
GLAUCOMA	NEUROPATHY	BLADDER PROBLEMS	HEART ATTACK
OSTEOPENIA/OSTEOPOROSIS		ULCERATIVE COLITIS	BIPOLAR
HEART DISEASE	CANCER	PARKINSON'S DISEASE	BLEEDING PROBLEMS
PEPTIC ULCER	HEADACHES	KIDNEY STONES	KIDNEY DISEASE
HIATAL HERNIA		CROHN'S DISEASE	
PULMONARY EMBOLISM			

OTHER MEDICAL PROBLEMS: _____

SURGICAL HISTORY & DATE: _____

_____

_____

SMOKING/TOBACCO USE:____CURRENT____PAST____NEVER____TYPE____AMT____YRS

ALCOHOL:____CURRENT____PAST____NEVER____DRINKS PER WEEK

RECREATIONAL DRUG USE:____CURRENT____PAST____NEVER____TYPE

FAMILY HISTORY:

FATHER: LIVING AGE ____ DECEASED AGE ____

ALCOHOLISM BIPOLAR DEPRESSION HIGH CHOLESTEROL OSTEOPOROSIS ANEMIA

CANCER _____ DIABETES 1 OR 2 HIGH BLOOD PRESSURE STROKE ASTHMA

COPD BLOOD CLOT KIDNEY DISEASE THYROID DISORDER ARTHRITIS DEMENTIA

HEART DISEASE MIGRAINES OTHER _____

MOTHER: LIVING AGE ____ DECEASED AGE ____

ALCOHOLISM BIPOLAR DEPRESSION HIGH CHOLESTEROL OSTEOPOROSIS ANEMIA

CANCER _____ DIABETES 1 OR 2 HIGHBLOOD PRESSURE STROKE ASTHMA COPD

BLOOD CLOT KIDNEY DISEASE THYROID DISORDER ARTHRITIS DEMENTIA MIGRAINES

HEART DISEASE OTHER _____

SIBLINGS: _____

_____

LIST ALL MEDICAL PROVIDERS YOU SEE ON A REGULAR BASIS & WHY:

_____

_____

PATIENT SIGNATURE:_____DATE_____