Michael W. Johnston, M. D.
Family Practice

INFORMATION SHEET

PATIENT'S NAME (LAST) (FIRST) (MIDDLE)

MAILING ADDRESS	(CITY)	(STATE)	(ZIP)
BIRTHDATE (MONTH) (DATE) (YEAR)	SEX (MALE OR FEMALE)	SOCIAL SECURITY NUMBER	HOME TELEPHONE NUMBER
PLACE OF EMPLOYMENT	BUSINESS PHONE NUMBER		

MARTIAL STATUS: SINGLE__________ MARRIED__________ DIVORCE__________ WIDOWED__________ SEPARATED__________

IF YOU WOULD LIKE FOR US TO FILE YOUR INSURANCE, PLEASE PROVIDE THE FOLLOWING INFORMATION AND A COPY OF YOUR INSURANCE CARD:

NAME OF INSURANCE (IF ANY)		POLICY NUMBER
NAME OF INSURED	INSURED'S DATE OF BIRTH	INSURED'S SOCIAL SECURITY NUMBER
IF MARRIED: SPOUSE'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
SPOUSE'S EMPLOYMENT		PHONE NUMBER
IF A MINOR: PARENT OR GAURDIAN'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

PERSON RESPOSIBLE FOR THE BILL	METHOD OF PAYMENT (CASH OR PHENIX CITY CHECK)
NAME OF FRIEND OR RELATIVE (EMERGENCY)	PHONE NUMBER
I WAS REFERRED BY:	REASON:

ALLERGIES:____

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED BY DR. MICHAEL W. JOHNSTON?

IF YES, NAME:____

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE BEING RENDERED.WE DO FILE MEDICARE AND BLUE CROSS. ANY OTHER INSURANCES, WE CAN CALL FOR BENEFITS ON AS A SERVICE. ALL FORMS ARE FILLED OUT FOR A SMALL CHARGE.

AUTHORIZATION: I HEREBY AUTHORIZE MICHAEL W. JOHNSTON, M. D. TO TREAT ME. I AUTHORIZE RELEASE OF MEDICAL INFORMATION TO MY INSURANCE COMPANY. I ASSIGN BENEFITS OF ANY INSURANCE FILED BY MY PHYSICIAN TO MICHAEL W. JOHNSTON, M. D., AND I UNDERSTAND THAT I AM RESPONSIBLE FOR THE CHARGES FOR SUCH MEDICAL SERVICES RENDERED.

SIGNED:____ DATE:__________________

RELATIONSHIP TO PATIENT:____