WILLIAM EARL FOX, M.D.

675 Peter Jefferson Parkway

Suite 335

Charlottesville, VA 22911

PATIENT REGISTRATION

Patient Information:

Date: _____

Patient's Legal Name: _____ Nickname: _____ Sex(M or F): _____

Patient Address:_____

City:_____ State:_____ Zip Code:_____

Date of Birth:_____ Marital Status:_____

Home Phone: _____ Cell Phone:_____ Work Phone:_____

Email Address:_____

Emergency Contact:_____ Rel. to Pt.:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Preferred Pharmacy:_____ Do you have any Allergies to Medications?:_____If yes,

please list:_____

Referral source: _____

Insurance Information for Prior Authorization:

Health Insurance Provider: _____ Policy Holder's Full Name: _____

Policy Group Number:_____ Policy ID Number:_____

Billing and Payment Information:

Person Responsible for Bill and Payment: _____ Rel. to Pt.: _____

Address for Person Responsible: _____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

PLEASE NOTIFY OUR OFFICE IF AT ANYTIME THE ABOVE INFORMATION YOU PROVIDED NEEDS UPDATING