James J. Crossley, M.D.
100 E. Northwood Street
Greensboro, NC 27401

ACCOUNT #:_____ DATE: _____

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

ADDRESS_____

CITY_____STATE_____ZIP CODE _____

BIRTHDATE_____SEX _____AGE _____SOCIAL SECURITY_____

HOME PHONE # (___)_____CELL# (___)_____WORK# _____

REFERRED BY:_____MEDICAL DOCTOR:_____

DRUG ALLERGIES:_____

MEDICATIONS:_____

_____

DO YOU SMOKE? YES _____NO _____ QUIT DATE? _____

ARE YOU A DIABETIC? YES _____NO_____ DO YOU HAVE HIGH BLOOD PRESSURE? YES _____NO_____

_____ **$** _____
INSURANCE NAME **SPECIALTY COPAY**

_____
INSURANCE CLAIMS ADDRESS

_____

I understand that payment of the incurred bill is the responsibility of the Patient and/or Guardian. If the bill has not been satisfied within 60 days, it is the responsibility of the Patient and/or Guardian to pay the outstanding balance. I authorize payment of the insurance benefits directly to James J. Crossley, M.D., and also authorize the release of any pertinent information to insurance carriers, third party payors, or others involved in the processing of this claim.

SIGNATURE_____
PATIENT OR GUARDIAN **DATE**