

REGISTRATION FORM

Betsy McCarley Billys, M.D.
Rhonda Bonilla, F.N.P.

PATIENT INFORMATION (please print)

Name _____ Date of Birth _____

Social Security# _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Employer _____ Occupation _____

Work Address _____ City _____ State _____ Zip _____

Spouse/Parent _____ Work Phone _____

Spouses Employer /Parent _____ Work Address _____

Who Referred You Here _____ Personal Physician _____

Emergency contact person _____ Phone# _____

Primary Insurance Information (Please provide copies of all cards to receptionist)

Name of Insured _____ Relation to Patient _____

Insurance Company _____

Secondary Insurance Information

Name of Insured _____ Relation to Patient _____

Insurance Company _____

Dr. McCarley Billys is not a provider for (does not bill) any Insurance Company except Medicare.

Signed _____ Date _____

Signed _____ Date _____

Signed _____ Date _____

Signed _____ Date _____