Walton K. Joyner, Jr., M.D.
3900 Browning Place, Suite 200
Raleigh, NC 27609

Welcome To Our Office

Please Print Clearly

_____ **Date**_____
(Last Name) **(Legal First Name)** **(M.I.)**

Address_____

City_____ State _____ Zip Code_____

Telephone# Home: _____ Work: _____ Cell: _____

Date of Birth _____ Age _____ Assigned Gender _____

E-mail _____ In Case of Emergency Phone #_____

Occupation_____ Employer _____
Spouse/Partner's Name_____ Date of Birth_____ Employer_____

Name of Insured _____ Date of Birth _____
Address of Insured if different from above _____
If under 18 yrs old: Name of Parent(s) _____
Family members that are patients and relationship to you _____
_____
Who May We Thank For Referring You _____

Name of Primary Care Physician _____ Telephone# _____

Assignment and Release

I understand that I am financially responsible for all services received whether or not paid by my insurance. I certify that I, and/or my dependent(s) have insurance coverage and assign directly to **Walton Joyner Jr., M.D.** all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to my Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative and Relationship to Patient