DR. MARSHALL’S CONSULTING SERVICES, LLC
496-D Strawberry – Suite 1 *Christiansted * St. Croix * 00820
Office Phone: (340) 692- 8620
Business Cell: (340) 227-2881

Patient Registration Form

Name of Client: ______________________________Date:_____________

Date of Birth: __________________Social Security No: ______________

Phone Number: _________________ Cell Phone: ____________________
Leave Message: □ Voice Message □Text Message □Text & Voice Message

Physical Address: ____

Mailing Address: ____

Email Address: ____

Reason for Seeking Services: ____
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Insurance Information:

Name of Insurance Company: ______________________________________
Member ID: ____
Group Number: ____
Primary Insured Name: _________________ D.O.B.__________________

Emergency Contact Information:

Name: ____

Phone: ____

Relationship to patient: ____

Assignment and Release:

I certify that I, and/or my dependent(s) have insurance coverage with ________________ and assign directly to Dr. Marshall’s Consulting Services, LLC all insurance benefits, if, any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize that use of my signature on all insurance submissions.