REGISTRATION INFORMATION
INTERNAL MEDICINE

ANGELA BULLY, M.D.
Detroit Medical Center
Harper Professional Building

TAMMIE L. BULLY, M.D.
4160 John R, Suite 804
Detroit, MI 48201

Date_____ Home Phone (____) _____ Work Phone (_____) _____

Patient: _____
Last Name First M.I

Sex: □ M □ F Age:_____ Birthdate:_____-_____-_____ Social Security # _____

Address:_____ City/State:_____ Zip:_____

Emergency Contact Information

Name:_____

Relationship:_____ Phone (_____)_____

Insurance Information

Contract Holders:_____ Social Security#_____
Last Name First Name M.I.

Relationship to Patient:_____ Employer:_____

Insurance Company :_____ Phone(_____)_____

Address_____ City, State_____ Zip_____

Contract Number:_____ Group Number_____

Effective Date_____ Cancellation Date:_____

Source of Verification (See Attached Copy)_____
(Driver's License, Social Security Card, or Insurance Card)

IF YOU HAVE MORE THAN ONE COMMERCIAL INSURANCE PLEASE SEE THE RECEPTIONIST FOR AN ADDITIONAL FORM.

COMMERCIAL AUTHORIZATION

I certify that to the best of my knowledge the above information is correct. I authorize Dr Bully to review my insurance coverage with my insurance company as indicated above. I authorize any holder of medical information to release medical and other information to my insurance company for review of my coverage and/or for processing of claims for services rendered to me. I further authorize the release to Dr. Bully of such information as may be necessary for these purposes by my insurance company.

I hereby authorize you to pay directly to the below named doctor benefits due me out of my indemnity under the terms of my policy issued by your company.

Angela Bully, M.D., P.L.L.C.

Payment is authorized upon your receipt of itemized statement for services rendered. Payment of this amount as herein directed, in whole or in part, shall be considered the same as if paid by your company directly to me. I permit a copy of this authorization to be used in place of the original.

Signed_____ Date_____
(If insured is a minor, parent or guardian must sign)

Signature of Person Completing Form_____ Date_____