PATIENT INFORMATION SHEET

Referred By: ______________________

Patient Information

Name: ____
First | Middle | Maiden | Last | Preferred Name

Social Security No. ______________ Age: _____ Date of Birth: ___________________

Driver's License No. ____________________ State: ____________ Race: _________ Religion: _______________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Address: ____
Street | Apt. No. | City | State | Zip

Home # [ ] ________________ Cell # [ ] __________________ Work # [ ] _________________

Employer: _____________________ Address: ____________________________________

How long employed? ___________ Occupation: ____________________________________

Spouse or Guardian Data

Name: ____________________________________ Age: ________ Date of Birth ___________________________

Social Security No. ___________________________ Work Phone: [ ] _________________________

Employer: ____________________ Address: ____________________________________

How long employed? ____________ Occupation: ____________________________________

Insurance Data

(Please give a copy of all Insurance Cards to Receptionist)

Primary Insurance Carrier: ________________________________ Effective Date of Insurance: _______________

Group No. __________________ Policy No. __________________

Insured's Name: ____________________________________ Phone # to verify:_______________________

Secondary Insurance Carrier: ______________________________ Effective Date of Insurance: _______________

Group No. __________________ Policy No. __________________

Insured's Name: ____________________________________ Phone # to verify:_______________________

Medicaid No. __________________________ Medicare No. __________________________

Emergency Data

In case of emergency, please notify (other than husband):

Name: ____ Relationship: _____________________________

Address: ____

Phone No. [ ] _______________________________

I understand that payment is expected at the time services are rendered unless arrangements have been made prior to my scheduled appointment.

I hereby assign all payment of benefits to which I am entitled to be paid directly to my physician. I also authorize my physician to release any information needed to determine my medical benefits and I agree to be responsible for any claims not covered, rejected, or denied by my insurance company, Medicaid, or Medicare.

❑ I give permission to WGOG/WGLC to contact me via the following email address: ___________________________

____ _______________________________

Signature of Financially Responsible Party | Date