PATIENT INFORMATION

Name:______________________________ DOB: ______________

Address:______________________________ Sex: ______________

______________________________ Marital Status: ______________

Telephone:______________________________ Cell Phone: ______________

Place of Birth:______________________________ Email: ______________

Referred By:______________________________ SSN: ______________

Employer:______________________________ Occupation: ______________

Address:______________________________

____

Telephone:______________________________

Emergency Contact: ______________________________ Relationship: ______________

Telephone:______________________________

Preferred Pharmacy? ______________________________ Telephone#: ______________

Do you have a living will? Yes/No Do you have a Durable Power of Attorney for Health Care? Yes/No

IF YOU WOULD LIKE INFO ABOUT EITHER OF THE ABOVE, PLEASE ASK OUR OFFICE STAFF

INSURANCE INFORMATION

Primary Ins: ______________________________ Ins#: ______________

Address: ______________________________ Group# ______________

______________________________ Relationship: ______________

Subscriber: ______________________________ SSN: ______________

Secondary Ins: ______________________________ Ins#: ______________

Address: ______________________________ Group#: ______________

______________________________ Relationship: ______________

Subscriber Name: ______________________________ SSN: ______________

AUTHORIZATIONS

Authorize all health care providers, including insurance companies, health organizations, and hospital and medical service corporations to pay directly to Wayland Medical Associates all benefits due under said policy by reason of service rendered. I also authorize the release of any medical information necessary to process claims for professional services rendered to me. I understand that I am financially responsible to Wayland Medical Associates for charges not covered by this authorization and do hereby agree upon receipt of bill to pay Wayland Medical Associates in full.

Authorize /refuse Wayland Medical Associates to obtain prescription history from outside sources to include other physicians and pharmacies.

Signature:______________________________ Date:______________

Relationship (if signed by family member):______________________________

FINANCIAL HISTORY

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand that such policies may be amended by the practice from time to time.

Signature:______________________________ Date:______________