Welcome To Our Office!

Name: _____ Today's Date: _____
First Middle Last

Home Address: _____
City: _____ State: _____ Zip: _____
Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____
SSN: _____ Birth Date: _____ Age: _____
Email Address: _____
May we contact you via Email? ☐ Yes ☐ No
Would you like to receive e-mails about our promotions and special offers? ☐ Yes ☐ No
Occupation: _____
Employer: _____ Years There: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____
Relationship to Patient: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____
SSN: _____ Birth Date: _____ Age: _____
Occupation: _____
Employer: _____ Years There: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____

Name of Spouse: _____ Birth Date: _____ Age: _____
Occupation: _____ SSN: _____
Employer: _____ Years There: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Employer's Telephone: ( ) _____

In case of emergency, contact: _____
Relationship to Patient: _____
Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____
May we contact your emergency contact for billing or insurance matters? ☐ Yes ☐ No
How did you learn about our practice? _____
If someone referred you, whom may we thank? _____

Do you wish phone calls to be confidential? ☐ Yes ☐ No
May we contact you at work? ☐ Yes ☐ No
Preferred method of contact: ☐ Home ☐ Work ☐ Cell ☐ Email ☐ Text

Insurance Information

Patient's Name:_____ Today's Date:_____
First Middle Last

[Primary Insurance] ρ ***Please enter information for the Insured Party.***
Name of Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____ Insured's Date of Birth: _____
Patient Relationship to the Insured Party: _____ Gender: _____
Policy ID Number: _____ Group Number: _____

[Secondary Insurance] ρ ***Please enter information for the Insured Party.***
Name of Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____ Insured's Date of Birth: _____
Patient Relationship to the Insured Party: _____ Gender: _____
Policy ID Number: _____ Group Number: _____

Did your injury happen on the job? ☐ Yes ☐ No

If "Yes," on what date did the injury occur? _____

Did you report the accident to your employer? ☐ Yes ☐ No

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay and non-covered service amounts.

Method of Payment for Today's Visit: ☐ Cash ☐ Check ☐ Visa/MC

In addition to the principal amount owed, I agree to pay 33.33% of the unpaid balance as collection fees if my account is turned over to a collection agency. I further agree to pay reasonable attorney fees and court costs arising out of any litigation concerning the collection of this account.

Signature of Patient or Responsible Party: _____

Date: _____

I authorize the release of any medical information necessary to process my claim.

Signed:

_____
(Patient or responsible party)

Date: _____

I authorize payment of medical and surgical benefits to
Gary Wiesman, MD.

Signed:

_____
(Patient or responsible party)

Date: _____