

# Welcome To Our Office!

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
First Middle Last

Home Address: \_\_\_\_\_ Apt. \_\_\_\_\_

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: \_\_\_\_\_ Apt. \_\_\_\_\_

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? \_\_\_\_\_

# Insurance Information

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
                          First                          Middle                          Last

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

*[Primary Insurance] \* 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] \* 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    Credit Card

<p>I authorize the release of any medical information necessary to process my claim.</p> <p>Signed: _____</p> <p>(Patient or responsible party)</p> <p>Date: _____</p>
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<p>I authorize payment of medical and surgical benefits to <u>Gary Wiesman, MD.</u></p> <p>Signed: _____</p> <p>(Patient or responsible party)</p> <p>Date: _____</p>
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