PATIENT INFORMATION **MR#_______**

PATIENT NAME SOCIAL SECURITY NUMBER

____ _________________________

PATIENT ADDRESS

____

STREET OR P.O. BOX, CITY, STATE AND ZIP CODE

DATE OF BIRTH _______________________ SEX _____F _____M

DAYTIME PHONE NUMBER ALTERNATE PHONE NUMBER

________________________ __________________________

E-MAIL ADDRESS ____

EMPLOYER EMPLOYER PHONE NUMBER

____ ________________________

CONTACT IN CASE OF EMERGENCY

NAME	RELATIONSHIP	HOME/CELL PHONE	WORK PHONE
1.______________________	_______________	_______________	_______________
2.______________________	_______________	_______________	_______________
3.______________________	_______________	_______________	_______________

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: ______________________________
GROUP/ID NUMBER: _______________________
SUSCRIBER NAME (IF DIFFERENT FROM PATIENT):

____
SUBSCRIBER EMPLOYER: __________________________________
SUBSCRIBER DATE OF BIRTH:________________
SECONDARY INSURANCE NAME: ____________________________
GROUP/ID NUMBER: _______________________
SUSCRIBER NAME (IF DIFFERENT FROM PATIENT):

____
SUBSCRIBER EMPLOYER: ___________________________________
SUBSCRIBER DATE OF BIRTH:________________

ALL PROFESIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL CHARGES/PAYMENTS. REGARDLESS OF INSURANCE COVERAGE, CO-PAYMENTS ARE DUE WHEN SERVICES ARE RENDERED.

I hereby authorize payment of benefits to be made by either me or on my behalf to WILSON MEDICAL ASSOCIATES for services provided to me by WMA. I understand that there may be charges incurred by me at WMA that are considered a non-covered charge by Medicare and/or private insurance. I understand that I am financially responsible for these non-covered charges. I authorize refund of overpaid insurance benefits whereby coverage is subject to coordination of benefits. In the event of default, I agree to pay all cost of collections, including reasonable attorney fees. In Medicare un-assigned cases I am responsible for payment at the time of service. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or any public agency and its agent to determine benefits for services provided or benefits for related services.

SIGNATURE: _______________________________DATE: ____________________