Patient Information Form

Month Day Year

Today's Date: / /

Referred By:

Primary Care Physician:

Last Name:

First Name:

Middle:

Mailing Address:

City: Sate: Zip:

Home Phone: Work Phone

Cell Phone Age

Marital Status: Single Married Divorced Separated Widowed

Month Day Year

Date of Birth: / / SSN#:

Occupation: Employer:

Spouse or Parent if Minor: Spouse Occupation:

Spouse Employer: Spouse (parent) Work Phone:

Month Day Year

Date of Birth: / / SSN#:

(if Spouse or Parent)

Please List Any Drug Alergies:

I authorize you to contact me Using my Email Address, Which is:

or my Work Email, Which is:

How Did You Hear About Our Office?

Insurance Information

(Please give card to receptionist to be copied)

Primary Insurance Company:

Address:

City: Sate: Zip:

Policyholder's Name/Relation:

ID #:

Group #:

Insurance Phone Number:

Date of Birth of Policyholder: Month / Day / Year Policyholder SSN#:

In Case of Emergency, Please Notify

First & Last Name, Contact 1:

Address:

City: Sate: Zip:

First & Last Name, Contact 2:

Address:

City: Sate: Zip:

Insurance Authorization and Consent

I request that payment of authorized Medicare or other insurance company benefits be made directly to Dr. Edward Williams for services rendered by this clinic who accepts assignment.

I authorize release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow my medical records to be faxed if necessary and understand this does fall under HIPAA regulations.

I understand that clicking the "I agree" box below requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare/Other Insurance company assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare/Other Insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other Insurance Company.

☐ I agree to the terms above

Date: Month / Day / Year

Signature: ____________________