PATIENT INFORMATION

THANK YOU FOR CHOOSING OUR OFFICE. **DATE**_____
PLEASE PRINT CLEARLY

Patient Name_____ Age_____
Sex_____

Birthdate_____ Single_____ Married_____ Widowed_____
Divorced_____

Address_____ Apt._____ Phone #_____

City_____ State_____ Zip Code_____

Employer_____ Work Phone # _____

Cell Phone # _____Pager # _____ Email
_____

Social Security # _____ Occupation _____

Emergency Contact/Relation _____ Phone # _____

CONFIDENTIAL INFORMATION MAY BE LEFT AT (PHONE #)_____

Person Responsible for Payment:

Name_____ Relation to Patient_____ Phone #
_____

Employer _____ Work Phone # _____ Ext. _____

Social Security # _____ Date of Birth _____

Spouse's Name _____ Work Phone # _____

Employer _____

PLEASE PROVIDE COPY OF INSURANCE CARD

Medical Insurance: Yes ____ No ____ Insurance Company _____

PCP: _____ Referred By: _____

Have you or any family members been seen here? Yes ____ No ____

List any allergies _____

Your Pharmacy _____ Pharmacy Phone # _____

90 DAY PRESCRIPTION PLAN ? YES____ NO ____

I understand that it is my responsibility to provide this office with my current insurance information. Copays, deductibles and/or % are due and payable at the time of service. I understand that not all services may be covered by my insurance. I will be financially responsible for all non-covered services. Some services in this office are provided by a Certified Physician Assistant.

ASSIGNMENT OF BENEFITS:
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which i am entitled, including Medicare, private insurance, and any other health plan to Paul S. Worell, D.O. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment for services rendered.

Signed_____ Date_____