WAYNE MEMORIAL COMMUNITY HEALTH CENTERS

DATE _____________ **FIRST NAME** ________________________**MIDDLE** ________ **LAST NAME** ___________________________

DATE OF BIRTH ___________________ **MARITAL STATUS:** ______________ **PRIOR LAST NAME** ______________________

ADDRESS: ____ **HOME PHONE:** ______________________________

____ **CELL PHONE:** ______________________________

EMAIL: ____ **ALTERNATE PHONE:** ______________________________

CONTACT BY: Circle One: Home Phone Cell Phone Email SEX : M F SOCIAL SECURITY # ____________________ ____

PERSON TO NOTIFY IN CASE OF EMERGENCY _____________________________________ **TELEPHONE #** ___________________

FAMILY (PRIMARY CARE) PHYSICIAN: ____

HOW WERE YOU REFERRED TO OUR OFFICE:____

IF MINOR CHILD – NAME OF PARENT OR GUARDIAN: ____

*** GUARANTOR IS THE PERSON FINANCIALY RESPONSIBLE FOR BALANCES. IF OTHER THAN THE PATIENT PLEASE PROVIDE REQUIRED INFORMATION- GUARANTOR IS: PATIENT OTHER** ______________________________________

ADDRESS; ____**DATE OF BIRTH** ___________________

SOCIAL SECURITY #__________________________________ **TELEPHONE # OF GUARANTOR:** ___________________________

INSURANCE INFORMATION-PLEASE PROVIDE CARD

PATIENT WILL BE CONSIDERED A SELF-PAY ACCOUNT UNTIL INFORMATION IS PROVIDED

PRIMARY INSURANCE: ____ _________________

INSURANCE ADDRESS: ____

PRIMARY INSURANCE HOLDER INFORMATION: INSURED IS : PATIENT OTHER

INSURANCE ID# ____

GROUP ID# ____

NAME OF INSURED (POLICY HOLDER): ____

POLICYHOLDER DATE OF BIRTH: ____________________ **RELATIONSHIP TO PATIENT** _________________

ADDRESS OF INSURED: ____

TELEPHONE NUMBER OF INSURED: ____

SOCIAL SECURITY NUMBER OF INSURED: ____

SECONDARY INSURANCE: ____ _________________

INSURANCE ADDRESS ____

SECONDARY INSURANCE HOLDER INFORMATION: INSURED IS: PATIENT OTHER

INSURANCE ID# ____

GROUP ID# ____

NAME OF INSURED (POLICY HOLDER) : ____

POLICYHOLDER DATE OF BIRTH: ____________________ **RELATIONSHIP TO PATIENT** _________________

ADDRESS OF INSURED: ____

TELEPHONE NUMBER OF INSURED: ____

SOCIAL SECURITY NUMBER OF INSURED: ____

PHARMACY PREFERENCE _________________________ **CITY/STATE** ____

I undersigned, hereby CONSENT TO TREATMENT and grant permission to release my medical information and to authorize payment of health insurance benefits to the above-named doctor(s). I also understand that I am fully responsible for payment of deductibles and co-insurance and any charges that are incurred and not covered by my health insurance.

Signature: ____ **Date:** ____

PAYMENT: We accept cash, checks and credit cards. Payment is due upon receipt of medical services. Co-payments must be paid at the time of your visit. If financial arrangements are needed, please notify the receptionist, as approval will be needed before your visit.