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.