Wiggington Road Family Practice

Patient Information:

Patient's Name _____ Sex _____
Last First M.I.

Address(mailing)_____ City_____ State____ Zip_____

Phone_____
Home Work Cell

Social Security # _____ Date of Birth_____ Age_____

Marital Status Married Single Divorced Widowed

**If patient is a minor:**

Father's Name_____ Home #_____ Work #_____

Mother's Name_____ Home#_____ Work#_____

Employer's Name_____

Employer's Address_____

Supervisor's Name and phone number_____

Emergency Contact (someone outside of the home)name/relation_____

Emergency Contact Home Phone_____ Work Phone_____

Spouse's Name_____

Spouse's Employer_____ Work Phone_____

Names of People in Your Household_____

Whom may we thank for referring you_____

**Responsible Party Information**

Person Responsible for Payment_____

Address_____

Phone Number_____

Insurance Company Information:

Company Name_____

## SEE COPY OF INSURANCE CARD

A photocopy of this agreement shall be considered as effective and valid as the original.

**Authorization to release information and to pay benefits to Wiggington Road Family Practice.**

I hereby authorize the designated physician to release information acquired in the course of my examination and treatment. I hereby assign payment directly to the designated physician for any medical/surgical procedures and/or services performed. If I provide incorrect information about my insurance company and the claim is denied, I will be billed the balance of the claim. I also authorize my physician to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I agree that default of payment will subject the account to all collection fees including court costs and attorney fees at 33.3% and interest at 18% if applicable. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

Patient's Signature_____ Date_____

If Minor, Parent or Guardian Signature_____ Date_____

Payment is expected at time of service