New patient form (We are open to new patients. Please call our office or fill out this form)

First Name

_____

Street Address

_____ _____ _____

City State Zip Code

____ ____ ____ - ____ ____ - ____ ____ ____ ____ S M D W

Social Security No. Marital Status (circle one)

_____/_____/_____ _____ _ M _ F

Date of Birth Age Sex

(_____)-_____ (_____)-_____

Home Phone No. Work Phone No.

(_____)-_____ _____

Cellular Phone No. E-mail Address

_____

Employer

_____

Employer Address

_____ _____

Occupation Hours Worked

Person Responsible for Account:

_____ _____ _____

Last First MI

_____

Street Address

_____ _____ _____

City State Zip Code

____ ____ ____ - ____ ____ - ____ ____ ____ ____ S M D W

Social Security No. Marital Status (circle one)

_____ _____/_____/_____ _ M _ F

Relationship Date of Birth Sex

(_____)-_____ (_____)-_____

Home Phone No. Work Phone No.

(_____)-_____ _____

Cellular Phone No. E-mail Address

_____

Employer

_____

Employer Address

_____ _____

Occupation Hours Worked

_____ _____

PRIMARY INSURANCE Primary Insurance Address

_____ _____

Subscriber Name Relationship

____ ____ ____ - ____ ____ - ____ ____ ____ ____ _____/_____/_____

Subscriber Social Security No. Subscriber Date of Birth

_____ _____

Subscriber/Policy No. Group/Plan No.

_____

Subscriber Employer

_____ _____

Co-Payment Amount Effective Date of Ins.

_____ _____

SECONDARY INSURANCE Secondary Insurance Address

_____ _____

Subscriber Name Relationship

____ ____ ____ - ____ ____ - ____ ____ ____ ____ _____/_____/_____

Subscriber Social Security No. Subscriber Date of Birth

_____ _____

Subscriber/Policy No. Group/Plan No.

_____

Subscriber Employer

_____ _____

Co-Payment Amount Effective Date of Ins.

I request that payment of authorized insurance benefits from any applicable insurance carrier be made on my behalf to Waukesha Family Practice Clinic, Ltd. for any services furnished me by that provider. I authorize medical information needed to determine these benefits or the benefits payable for the related services be released to the insurance company and its agents. I understand that even though I have some type of insurance coverage, I am responsible for the payment of services.

X_____ _____/_____/_____

X_____ _____/_____/_____

Signature of Patient; or Parent; or Responsible Party Date Witness Date

Name Birth Date Relationship

_____

_____

INSURANCE INFORMATION

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

OTHER FAMILY MEMBERS AT YOUR ADDRESS

Name Birth Date Relationship