WELLSTAR
Physicians Group

## PATIENT INFORMATION (Please print)

Full Name ______________________________ Nickname ______________
First Middle Last

Date of Birth ____/____/____ ❑ Male ❑ Female Social Security Number ____-____-____

Marital Status ______________ Home phone (___) ____________

Address ______________________________________________
Street Apartment # City State Zip

Employment: Company Name ______________________ Work Phone (___) ____________

Address ______________________________________________
Street City State Zip

Individual to contact in an emergency: Full Name ______________________
(Please list someone not in your household) First Middle Last

Relationship to patient ______________ Home phone (___) ________ Work Phone (___) ________

## RESPONSIBLE PARTY/GUARANTOR INFORMATION

Individual to Receive Bills ❑ Self (Skip this section) or Full Name ______________________
First Middle Last

Relationship to Patient ______________________ Social Security Number ____-____-____

❑ Male ❑ Female Date of Birth ______________ Home phone (___) ____________

Address ______________________________________________
Street Apartment # City State Zip

Employment: Company Name ______________________ Work Phone (___) ____________

Address ______________________________________________
Street City State Zip

## MEDICAL INSURANCE INFORMATION (Please submit your card(s) to be copied)

| | Insurance Company Name | Card/Policy Holder Name | Policy Number | Card/Policy Holder's Social Security # | Office Visit Copay Amount ($) |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |

## CARD/POLICY HOLDER INFORMATION

Card/Policy Holder is: ❑ Patient ❑ Responsible Party (Skip this section)

Full Name ______________________ Relationship to Patient ______________
First Middle Last

❑ Male ❑ Female Date of Birth ______________ Home phone (___) ____________

Address ______________________________________________
Street Apartment # City State Zip

Employment: Company Name ______________________ Work Phone (___) ____________

Address ______________________________________________
Street City State Zip

**Assignment of Benefit/Consent for Treatment:** I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all my charges not paid by my insurance. I hereby voluntarily consent to my treatment at this office and authorize such treatments, examinations, medications, anesthesia, surgical operations and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by my attending physicians. I have read this consent, am aware of its contents and fully understand the same. I acknowledge that no assurance or promises have been given to the patient concerning the results, which may be obtained by such treatments and procedures hereby, affirmed by the signature of the undersigned.

**PATIENT SIGNATURE:** ______________________ **DATE:** ____________

**GUARDIAN:** ______________________ **DATE:** ____________