

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