Wayland Medical Associates

PATIENT INFORMATION

Name: _____ DOB: _____
Address: _____ Sex: _____
_____
Telephone: _____ Marital Status: _____
Place of Birth: _____ Cell Phone: _____
Referral By: _____ Email: _____
Employer: _____ SSN: _____
Address: _____ Occupation: _____
_____
Telephone: _____

Emergency Contact: _____ Relationship:_____
Telephone:_____

Preferred Pharmacy:_____ Telephone:_____

Do you have a living will? **Yes / No** Do you have a Durable Power of Attorney for Health Care? **Yes / No**
IF YOU WOULD LIKE INFO ABOUT EITHER OF THE ABOVE, PLEASE ASK OUR OFFICE STAFF

INSURANCE INFORMATION

Primary Ins: _____ Ins#: _____
Address: _____ Group# _____
_____ Relationship: _____
Subscriber: _____ SSN: _____

Secondary Ins: _____ Ins#: _____
Address: _____ Group#: _____
_____ Relationship: _____
Subscriber Name:_____ SSN: _____

AUTHORIZATIONS

Authorization all health care providers, including insurance companies, health organizations, and hospital and medical service corporations to pay directly to Wayland Medical Associates all benefits due under said policy by reason of service rendered. I also authorize the release of any medical information to process claims for professional services rendered to me. I understand that I am financially responsible to Wayland Medical Associates for charges not covered by this authorization and do hereby agree receipt of bill to pay Wayland Medical Associates in full.
Authorize / Refuse Wayland Medical Associates to obtain prescription history from outside sources to include other physicians and pharmacies.
Signature:_____Date:_____
Relationship (if signed by family member):_____

Financial History

I have read and understand the practice's financial policy and I agree to be bound by the terms. I also understand that such policies may be amended by the practice from time to time.
Signature: _____Date:_____