Winston Medical Clinic

PATIENT INFORMATION SOCIAL SECURITY #_____

PATIENT NAME: _____ **DATE OF BIRTH:**_____
LAST FIRST MIDDLE

ADDRESS _____

ZIP CODE: _____ **CITY:** _____ **STATE:** _____ **HOME PHONE #:** (_____) _____

WORK PHONE #: (_____) _____ **CELL PHONE #:** (____) _____ **EMAIL ADDRESS:** _____

SEX: (circle one) M F **MARITAL STATUS**: (circle one) Single Married Divorced Widowed **ETHNICITY / RACE**: _____

PREFERRED LANGUAGE: _____ **PREFERRED PHARMACY:**_____

PATIENT'S EMPLOYER:_____ **OCCUPATION:**_____

CITY: _____ **STATE:** _____ **ZIP CODE:**_____ **EMPLOYER PHONE #:** _____

ACCIDENT INFORMATION: DATE OF ACCIDENT:_____ WORK RELATED:_____ AUTO:_____ OTHER:_____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESP. PARTY NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

DATE OF BIRTH: _____/_____/_____ **SOCIAL SECURITY NUMBER:** _____ **SEX:** (circle one) FEMALE MALE

HOME PHONE #: (_____) _____ **WORK PHONE #:** (_____) _____ **CELL PHONE #:** (_____) _____

RESPONSIBLE PARTY'S EMPLOYER_____ **CITY**_____ **STATE**_____

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (circle one) SELF SPOUSE CHILD OTHER

INSURANCE INFORMATION (PLEASE COMPLETE OR GIVE RECEPTIONIST YOUR CARD TO COPY)

PRIMARY INSURANCE COMPANY: _____

ADDRESS**:** _____ PHONE**:** _____ COPAY AMOUNT $_____

POLICY #: _____ **SUBSCRIBER'S NAME:** _____ **SS # OF INSURED**: _____

INSURED DOB:_____ **PATIENT RELATIONSHIP TO SUBSCRIBER**: (circle one) SELF SPOUSE CHILD OTHER

SECONDARY INSURANCE COMPANY:_____

ADDRESS**:** _____ PHONE**:** _____ COPAY AMOUNT $_____

POLICY #: _____ **SUBSCRIBER'S NAME:** _____ **SS # OF INSURED**: _____

INSURED DOB:_____ **PATIENT RELATIONSHIP TO SUBSCRIBER**: (circle one) SELF SPOUSE CHILD OTHER

How did you hear about us?

Friend/Family_____ Website_____ Social Media_____ Billboard_____ Radio Ad_____

SECTION 1

CONSENT FOR TREATMENT:

I do hereby authorize consent to such diagnostic procedures, tests and/or treatment deemed necessary by healthcare provider.

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made.

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. **You are responsible for all deductibles and charges not covered by insurance.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations; this is your responsibility. I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the Provider to release any medical or account information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Provider deems it necessary in order to ensure the best medical care on my behalf. I further authorize the release of information to my employer limited to matters involving on-the-job or work-related injuries. This includes the results of any drug or alcohol screening performed. I further understand that any person(s) that receive these medical records should not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

May we leave a message on your phone: (circle one) Yes No

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE (HOME) _____ (WORK) _____ (CELL) _____

I have read Section 1 and agree to terms and accept financial responsibility in full for this account.

SIGNED: _____ DATE: _____

Patient, Parent, or Guardian

If your employer is financially responsible, please sign below:

I have read Section 1 and agree to terms with my employer accepting financial responsibility.

PATIENT SIGNATURE: _____ DATE: _____