

THE WOODRUFF INSTITUTE

PATIENT INFORMATION (PLEASE PRINT)

Name _____ Today's Date ___/___/_____
Last First M.I.
Mailing Address _____
City State Zip
Alternative Address _____
City State Zip
Home Phone _____ Alt. Phone _____ Work Phone _____
Preferred Contact #: Home Alternate Work **(Please circle)** Email address: _____
SSN# _____ Date of Birth _____ Age _____ Sex _____ Marital Status _____

PATIENT OR RESPONSIBLE PARTY (if different from patient)

Name _____
Last First M.I.
Address _____
City State Zip
Home Phone _____ Alt. Phone _____ Work Phone _____

INSURANCE INFORMATION (Please present insurance card at time of check in.)

Primary Insurance Name _____ **Secondary** Insurance Name _____
Name of Insured _____ **Name of Insured** _____
Insured's SSN # _____ **Insured's SSN #** _____
Insured's Date of Birth _____ **Insured's Date of Birth** _____

Other family members that are patients _____
Pharmacy of choice _____ Phone _____
In case of Emergency, who should be notified? _____ Phone _____
Whom may we thank for referring you? _____
Primary Care Physician _____
How did you hear about the Woodruff Institute? _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Date ___/___/_____
Date

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. Our office will file insurance as a courtesy to you, to both your primary and secondary insurance carries. In the event your account must be turned over to collections, a \$50.00 collection fee will be added to your account. Your signature below signifies you have received a copy of our financial policies.

Patient or Responsible Party Signature: _____ Date ___/___/_____
Date