Patient Registration

Name:_____
Last First Middle

Address:_____
Street/Apt # City State ZIP Code

Date of Birth: _____ Social Security Number:_____-_____-_____

Single Married Widow Divorced Other Male Female

Home Telephone Number: _____

Cell Phone: _____

Work Telephone Number: _____

Place of Employment:_____

Email Address:_____

What Pharmacy will you be using:_____

Emergency Contact Information

Name/Relationship: _____

Home Phone #: _____ Work/Cell #:_____

Address:_____
Street/Apt# City State ZIP Code

Insurance Information

Primary:_____
Insurance Company Name

_____
Name of Subscriber

_____/_____/_____-____-_____
Subscriber Date of Birth Subscriber Social Security #

_____
Policy ID # Group ID #

Supplement:_____
Insurance Company Name

_____
Name of Subscriber

_____/_____/_____-____-_____
Subscriber Date of Birth Subscriber Social Security #

_____
Policy ID # Group ID #

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Bryan Weckel MD Family Medicine, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ _____
Signature of Patient / Guardian Date

_____ _____
Signature of Person Responsible for Payment Date