W. Steven Wilson, M.D.

Nicole Bizzell, N.P.

Board Certified Family Practice

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PATIENT INFORMATION

Patient's Name_____
Address:_____City:_____State:_____Zip:_____
Birth Date (MM/DD/YYYY):_____ Sex: M___F___ Marital Status: S___M___W___D___
Your Age:_____ Social Security Number:_____
Home Phone:_____ Work Phone:_____ Ext:___ Cell Phone:_____
Spouse's Full Name:_____
In Case of Emergency Call:_____Relationship:_____
Responsible Party/Parent:_____
Referred by: Yellow Pages_____ Friend_____ MD_____ Other_____

INSURANCE INFORMATION

Primary Insurance:_____ Card holder's Name:_____
SSN (REQUIRED):_____Cardholder's Birth date (REQUIRED)_____
Group Number:_____ Sex: M___F___ Co-Pay $_____
Employer:_____
Secondary Insurance:_____ Cardholder's Name:_____
SSN (REQUIRED):_____Cardholder's Birth date (REQUIRED)_____
Group Number:_____

EMPLOYMENT INFORMATION

Employer/School Name:_____
Address:_____
Is this a Workman's Comp Injury?:_____Supervisor/Person to Contact at Work_____

Assignment of Benefits

Your signature is required to process insurance claims and to ensure payment of services rendered.

The Non-Medicare Patient

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to W. Steven Wilson, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as the original. Furthermore, I agree to pay W. Steven Wilson, M.D. for services rendered unto me to treat my condition (i.e. medications, injections, x-rays, etc.) which my insurance company deems unnecessary.

The Medicare Patient

I request that the payment of authorized Medicare benefits be made to me or on my behalf to W. Steven Wilson, M.D. for any services furnished me by W. Steven Wilson, M.D. Furthermore, I agree to pay W. Steven Wilson, M.D. for services rendered unto me to treat my condition (i.e. medications, injections, x-rays, etc.) which my Medicare benefits may deem unnecessary.

I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine benefits or the benefit payable to related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment will remain in effect until revoked by me in writing. A photo copy of this assignment is to be considered as valid as the original. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDESTAND IT.

Patient Signature: _____ **Date:**_____
Witness: _____ **Date:**_____