a.wise MD

patient registration

personal information

First Name _____

Last Name _____

Address _____

City _____

Zip Code _____

Home Phone _____

Cell Phone _____

Work Phone _____

Email _____

Gender _____

Primary Language _____

Responsible Party _____

Relationship _____

SSN _____

Date of Birth _____

Marital Status _____

Occupation _____

Employer _____

emergency information

In case of emergency, notify _____

Relationship _____

Address _____

City _____

Zip Code _____

Home Phone _____

Work Phone _____

Cell Phone _____

insurance information

Primary Insurance Name _____

Subscriber's Name _____

Subscriber's DOB _____

Group # _____

Tel _____

Subscriber's SSN _____

Member ID# _____

Billing Address _____

Secondary Insurance Name _____

Subscriber's Name _____

Subscriber's DOB _____

Group # _____

Tel _____

Subscriber's SSN _____

Member ID# _____

Billing Address _____

I request that payment of insurance benefits be made, on my behalf, to Alphaeus Wise, M.D., for any services furnished by said physician. I authorize any holder of medical information needed to determine these benefits payable to related services. For Medicare, the physician agrees to accept assignment, and I am only responsible for deductibles, co-insurance, and any non-covered services. **I understand that in all other cases, I am financially responsible for the payment of any and all charges incurred with Alphaeus Wise, M.D.** I authorize Alphaeus Wise, M.D., to furnish information to insurance carriers concerning my diagnosis and treatments.

_____

Signature (Patient or Guardian) Date