PLEASE PRINT CLEARLY
FRONT AND BACK SIDES

PATIENT INFORMATION SHEET

DATE ____________________

PATIENT LAST NAME ________________________ FIRST NAME ____________________ MIDDLE INITIAL ______ AGE _____

ADDRESS ______________________________________ CITY __________________ STATE ____ ZIP ________

❑ EMPLOYED MARITAL STATUS: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed CELL # ____________________

HOME PHONE ________________________ BIRTHDATE ______________ SS NUMBER ______________________

PATIENT'S EMPLOYER ____ PHONE ____________________

ADDRESS ____ OCCUPATION ______________________

HUSBAND'S NAME ____ SS# ______________ BIRTHDATE ________

HUSBAND'S EMPLOYER ____ WORK PHONE _________________

ADDRESS ____ OCCUPATION ______________________

IN CASE OF EMERGENCY NOTIFY ____________________________________ RELATIONSHIP ____________________

DAY PHONE _______________________ NIGHT PHONE ____________________

REFERRED BY ____

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HUSBAND'S EMPLOYER ____ WORK PHONE _________________

ADDRESS ____ OCCUPATION ______________________

IN CASE OF EMERGENCY NOTIFY ____________________________________ RELATIONSHIP ____________________

DAY PHONE _______________________ NIGHT PHONE ____________________

REFERRED BY ____

PRIMARY INSURANCE COMPANY ____

ADDRESS ______________________ CITY ______________ STATE _____ ZIP ________

POLICY HOLDERS NAME ____________________ BIRTHDATE ________ SS# __________ PHONE ________

ADDRESS IF DIFFERENT FROM PATIENT ______________________ RELATIONSHIP TO PATIENT ________

IDENTIFICATION NUMBER ______________________ GROUP NUMBER ______________

GROUP NAME ______________________ PHONE NUMBER OF INSURANCE COMPANY ______________

SECONDARY INSURANCE COMPANY ____

ADDRESS ______________________ CITY ______________ STATE _____ ZIP ________

POLICY HOLDERS NAME ____________________ BIRTHDATE ________ SS# __________ PHONE ________

ADDRESS IF DIFFERENT FROM PATIENT ______________________ RELATIONSHIP TO PATIENT ________

IDENTIFICATION NUMBER ______________________ GROUP NUMBER ______________

GROUP NAME ______________________ PHONE NUMBER OF INSURANCE COMPANY ______________

ASSIGNMENT OF BENEFITS: I hereby assign payment of any medical and/or surgical benefits, to include major medical benefits to which I am entitled, to be made to Darin L. Weyhrich, M.D. for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. I acknowledge receipt of privacy practices.

DATE ____________________ SIGNATURE ________________________________

PRIMARY INSURANCE COMPANY ____

ADDRESS ______________________ CITY ______________ STATE _____ ZIP ________

POLICY HOLDERS NAME ____________________ BIRTHDATE ________ SS# __________ PHONE ________

ADDRESS IF DIFFERENT FROM PATIENT ______________________ RELATIONSHIP TO PATIENT ________

IDENTIFICATION NUMBER ______________________ GROUP NUMBER ______________

GROUP NAME ______________________ PHONE NUMBER OF INSURANCE COMPANY ______________

SECONDARY INSURANCE COMPANY ____

ADDRESS ______________________ CITY ______________ STATE _____ ZIP ________

POLICY HOLDERS NAME ____________________ BIRTHDATE ________ SS# __________ PHONE ________

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