WILLIAM E. WOODS, M.D., S.C.

PATIENT INFORMATION SHEET

Name _____

Last **First** **MI**

Address _____ **Apt.** _____
StreetCityStateZip code

Phone Home ( ) _____ **Work: ( )** _____ **Cell: ( )** _____

Date of Birth _____ **Soc Sec #** _____

Marital Status: _____ **Single** _____ **Married** _____ **Widowed** _____ **Divorced** _____ **Separated**

HOW WERE YOU REFERRED TO OUR OFFICE? _____ ***** **PCP** _____

Patient Employer _____ **How Long?** _____

Address _____
StreetCityStateZip code

Patient Occupation _____

Insurance Policyholder's Name _____ **(If patient, skip to Emergency Contact)**

Policyholder Employer _____ **How Long?**_____

Address _____
StreetCityStateZip code

Phone ( ) _____ **Occupation** _____

Policyholder Soc Sec # _____ **Policyholder's DOB** _____

EMERGENCY CONTACT:
Name _____ **Relationship** _____ **Phone** _____

PRIMARY INS. COMP. _____ **SECONDARY INS. COMP.** _____

Policyholder Name _____ **Policyholder name** _____

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PRIVACY NOTICE ACKNOWLEDGMENT By signing below, I acknowledge I have been made aware of the William E. Woods, MDSC's Privacy Notice.

PATIENT SIGNATURE _____ **DATE**_____ **WITNESS** _____

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I hereby authorize the release of any medical or other information necessary to process my insurance claim. I authorize payment of medical benefits directly to William E. Woods, M.D., S.C. for services rendered. If insurance is denied, I assume responsibility for my bill.

PATIENT SIGNATURE _____ **DATE** _____