2010

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

PATIENT INFORMATION SHEET

Name ____

Last **First** **MI**

Address ____ **Apt.** ____________

Street **City** **State** **Zip 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 ____

Street **City** **State** **Zip code**

Patient Occupation ____

Insurance Policyholder's Name ____

(If patient, skip to Emergency Contact)

Policyholder Employer ______________________________________ **How Long?**______________________

Address ____

Street City State Zip code

Phone ( ) _______________ **Occupation** ____

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

EMERGENCY CONTACT:

Name _______________________________ **Relationship** ____________________ **Phone** ________________

PRIMARY INS. COMP. ___________________________ **SECONDARY INS. COMP.** ____________________

Policyholder Name ______________________________ **Policyholder name** ____________________________

****

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** _______________________

****

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** ____________________