

PATIENT INFORMATION

Name: _____ []Male []Female

Is the patient a minor? []Yes []No (If Yes, Please use Custodial Parent or Guardian's Address and phone numbers)

Address: _____ City, State, Zip Code: _____

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

Date of Birth: ____/____/____ Age: ____ Driver's License No. & State: _____

Email: _____ **PATIENT'S Social Security Number:** ____-____-____

Marital Status: []Married (Spouse's Name) _____ []Single []Divorced []Widow

Emergency Contact: _____ Phone: _____
(Someone who does not live with you)

Primary Care Physician: _____ Phone: _____

How did you hear about Dr. Wishnew? _____
(i.e. physician, emergency room, friend, website)

Employer: _____ Address: _____

Position/Job Description: _____

Reason for visit: _____

MEDICATIONS & ALLERGIES

List any medications you take on a regular basis. If none, please write "none".

List any medications to which you have had allergic reactions. If none, please write "none".

MEDICAL HISTORY

Surgeries: _____

Hospitalizations: _____

Medical Problems: _____

FAMILY HISTORY

Has any member of your family (parents, grandparents, brothers or sisters) had any of the following medical problems? If yes, please indicate who.

	Relationship		Relationship
Diabetes	Yes/No _____	Kidney Disease	Yes/No _____
High Blood Pressure	Yes/No _____	Alcohol Abuse	Yes/No _____
Heart Disease	Yes/No _____	Seizures	Yes/No _____
Arthritis	Yes/No _____	Cancer	Yes/No _____

HABITS

Cigarettes/Cigars? How many per day? _____

Smokeless Tobacco? How much per day? _____

Alcohol? How often? _____

INSURANCE INFORMATION

(Please provide the front desk staff with your insurance card and a picture ID)

Primary Insurance Co. Name: _____

Who is the Insured? []Self []Spouse []Parent Insured's Name: _____

Insured's Date of Birth: ____/____/____

Member/Insured's ID # _____ Group/Policy # _____

Member/Insured's Employer Name: _____

Employer's Address: _____ City, State, Zip Code: _____

Employer's Phone Number: _____

Secondary Insurance Co. Name: _____

Who is the Insured? []Self []Spouse []Parent Insured's Name: _____

Insured's Date of Birth: ____/____/____

Member/Insured's ID # _____ Group/Policy # _____

Member/Insured's Employer Name: _____

Employer's Address: _____ City, State, Zip Code: _____

Employer's Phone Number: _____

Authorization of Treatment and Release of Information

I grant permission for Dr. Wishnew to evaluate the patient's current complaint and prescribe any treatment and/or medications as may be deemed necessary. I authorize the release of medical information, including the diagnosis that may be necessary for insurance payment and referrals to other doctors/facilities.

I understand that I am expected to keep all follow-up appointments as instructed by Dr. Wishnew. I also understand that Dr. Wishnew and his staff are not responsible for notifying me of missed appointments.

Office Policy Concerning Payment , Billing, & Privacy Practices

I understand that payment is expected at the time of service. We accept cash, check (certified or personal), Visa or Mastercard.

I authorize David S. Wishnew, M.D., P.A. to submit claims to Medicare and/or any other Medical Insurance Carrier and the benefits payable to David S. Wishnew, M.D., P.A. on assigned claims. Insurance claims are filed as a courtesy to our patients. The insured is required to provide proof of coverage and amount of deductible already met, and is responsible for paying any remaining deductible, co-insurance, and non-covered charges. It is the responsibility of the insured to see that our claim is paid. Any changes in insurance status should be promptly reported to the office staff.

If our charges are not paid within 60 days from the date of service, your account may be considered delinquent and further collection activity may be necessary. If so, 50% of the unpaid balance will be added to all accounts referred for collection.

*I also acknowledge that I have been presented with a copy of David S. Wishnew's **Notice of Privacy Practices**:*

Signed: _____ Date: _____