Patient Check In

WBCMC - Central

Patient Last Name ____________________ Home Phone __________ Work Phone __________
First Name __________ Middle __________ Cell Phone __________ Other __________
Address ____________________ DOB __________ Sex __________ Marital Status __________
____________________ Driver's License __________
City __________ State ______ Zip ______ Social Security No. __________
Emergency Contact ____________________ Carrell Clinic Physician __________
Name __________ Phone __________ Relationship __________

Patients Employer ____________________ Occupation __________
Address ____________________ Phone __________ Fax __________
____________________ E-Mail __________
City __________ State ______ Zip ______ Contact __________

Guarantor of account is adult accompanying minor patient

Guarantor's Last Name ____________________ Work Phone __________
First Name __________ Middle __________ Employer __________
Address ____________________ S.S. # __________ D.O.B. __________
City __________ State ______ Zip ______ Patient's Relationship to Guarantor __________

Primary Insurance, Circle One: HMO PPO POS

Company Name ____________________
Claims Address ____________________
City __________ State ______ Zip ______
Phone __________ Fax __________
Policy No __________ Group No __________
Insured Name ____________________
Address ____________________
City __________ State ______ Zip ______
SS# __________ DOB __________ Sex ______
Insured Employer ____________________
Address ____________________
Phone __________ Fax __________
Patient's Relationship to Insured __________

Secondary Insurance, Circle One: HMO PPO POS

Company Name ____________________
Claims Address ____________________
City __________ State ______ Zip ______
Phone __________ Fax __________
Policy No __________ Group No __________
Insured Name ____________________
Address ____________________
City __________ State ______ Zip ______
SS# __________ DOB __________ Sex ______
Insured Employer ____________________
Address ____________________
Phone __________ Fax __________
Patient's Relationship to Insured __________

MUST HAVE INSURED DOB OR CLAIM CANNOT BE FILED TO INSURANCE

Primary Care Physician ____________________ Phone __________
Address ____________________ City __________ State ____ Zip ______
Referring Physician ____________________ Phone __________
Address ____________________ City __________ State ____ Zip ______
Reason for visit (part of body)? ____________________ Right or Left? __________
Duration of Symptoms? ____________________
Circle One: Was this an accident? Y N On the Job? Y N Motor Vehicle Accident? Y N Date __________

RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize W. B. Carrell Memorial Clinic (the clinic) to furnish medical and billing information to my referring physician, other providers of medical services, my insurance provider(s), and/or my spouse or guardian as necessary to facilitate my medical care or to recover expenses for services rendered by health care providers of the clinic. I understand that I have the right to specify, in writing, that my private health information be restricted from dissemination to any or all of the above.

I hereby assign any and all insurance benefits to the clinic to pay my obligation for medical and/or surgical expenses. I understand that I am responsible for any charges which may be denied or excluded by my insurance provider(s), except those charges which are excluded based on a managed care contract between the insurance company and the clinic. I understand that I am financially responsible for all charges not covered by an insurance company.

Print Name ____________________ Signature ____________________ Date __________