WADDELL FAMILY MEDICINE, PC- PATIENT DATA

NAME__________________________________ DOB___________SOC. SEC ______-____-______
FIRST MI LAST

ADDRESS______________________________________ CITY___________________STATE____

CELL PHONE______________________

ZIP CODE____________HOME PHONE______________________E-MAIL___________________

MARITAL STATUS_______OCCUPATION_______________EMPLOYER_____________________

EMPLOYMENT ADDRESS_________________________________WORK PHONE______________

POLICYHOLDER OF HEALTH INSURANCE (if other than self) _____________________________

DOB of POLICYHOLDER ______________ EMPLOYER___________________________________

*** KINDLY INFORM THE RECEPTIONIST IF YOU HAVE A SECONDARY INSURANCE ***

NAMES of HOUSEHOLD MEMBERS	RELATION	DATE OF BIRTH

PLEASE APPOINT SOMEONE TO NOTIFY IN CASE OF EMERGENCY:

____
NAME RELATION PHONE

____
ADDRESS

OFFICE POLICIES

PRESCRIPTION REFILLS WILL BE PROVIDED DURING YOUR OFFICE VISIT. YOU WILL BE GIVEN AN AMOUNT TO LAST UNTIL YOUR NEXT OFFICE VISIT. PLEASE PLAN ACCORDINGLY AND MAKE YOUR NEXT APPOINTMENT BEFORE YOU RUN OUT OF MEDICATION. WE WILL ONLY DO REFILLS WITHOUT AN OFFICE VISIT ON RARE OCCASIONS.

WE DO NOT MAIL, FAX, OR PHONE-IN MAIL ORDER PRESCRIPTIONS. PLEASE ASK FOR A 90 DAY SUPPLY WHILE YOU ARE IN THE OFFICE.

APPOINTMENTS FOR WHICH YOU DO NOT SHOW OR THAT ARE CANCELLED WITHOUT A 24 HOUR NOTICE WILL INCUR A CHARGE OF $25.00.

BILLING AGREEMENT

I ACKNOWLEDGE FULL RESPONSIBILITY FOR PAYMENT OF SERVICES RENDERED TO ME. I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY INSURANCE COMPANY(S) CONCERNING ANY ILLNESS AND TREATMENT. I UNDERSTAND THAT, UNDER THE TERMS OF THE CONTRACT I HAVE WITH MY INSURANCE COMPANY, I MUST PAY ANY PRE-DETERMINED CO-PAYMENTS AT EVERY VISIT. **(PLEASE BE ADVISED THAT WE PREFER PAYMENT BY CASH OR CHECK.)** IF I HAVE INSURANCE THAT WADDELL FAMILY MEDICINE PARTICIPATES WITH, I AUTHORIZE ASSIGNMENT OF PAYMENT DIRECTLY TO DR. DAVID WADDELL FOR MEDICAL SERVICES RENDERED TO ME. IT IS MY RESPONSIBILITY TO MAKE SURE THAT DR. WADDELL IS LISTED AS MY PRIMARY CARE DOCTOR WITH MY INSURANCE COMPANY. IF THIS IS NOT THE CASE, I WILL BE BILLED DIRECTLY AND WILL BE RESPONSIBLE FOR FULL PAYMENT. IF I AM A PATIENT WITH NO INSURANCE COVERAGE, I AGREE TO PAY MY BALANCE IN FULL AT THE TIME SERVICES ARE RENDERED.

SIGNATURE: ____ DATE________________
PATIENT OR LEGAL GUARDIAN