

Patient Information Sheet

Have you previously been seen here? Yes No If yes, by whom? _____

Which Dr. do you wish to see? Dr. Whightsel Dr. Haller Dr. Schultheis Dr. Dust
(Gyne only) (Starting August 1, 2011)

If this Doctor is unable to accept you as a new patient, would you wish to consider any of the remaining physicians? Yes No

Reason for appointment: _____ Who is your Primary Care/Family Physician? _____

Are you pregnant? Yes No Last menstrual period: _____ Marital Status: Married Single Divorced Widowed

Patients Full Name: _____ Maiden Name: _____

Date of Birth: _____ Social Security Number: _____ Race: _____ Ethnicity: _____

Drivers License #: _____ Religion: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Phone # where you can be reached during office hours: _____

Leave Messages on voice mail: Yes No Appointments Billing Test Results

Leave Message with another person: Yes No Appointments Billing Test Results

Email: _____ Patients Employer: _____

Occupation: _____ Work Phone #: _____ If necessary may we call your work #? Yes No

Spouse/Guardian: _____ Date of Birth: _____ Social Security Number: _____

Spouse/ Guardian's Employer: _____

Preferred Pharmacy: _____ Address: _____ Phone: _____

How did you hear about our practice? _____ Referred by: _____

In case of emergency, contact (other than spouse): _____

Address _____ City: _____ Zip: _____ Phone: _____

Insurance Information

Primary Coverage, Name of Carrier & Address

Group #: _____

Identification #: _____

Subscriber DOB: _____ Effective Date: _____

Are you covered by Medicare? Yes No Medicare #: _____ Railroad? _____

Are you covered by Medicaid? Yes No Please provide the receptionist with a current copy of Medical Card.

Please bring your insurance card to all visits. Accurate and up-to-date insurance information will help speed the processing of your insurance claims. Be prepared to pay your co-pay at check-in. For your convenience, we accept cash, check, Visa, MasterCard, Discover, and American Express. Returned checks will be subject to additional fees.

We will file your insurance claims. Upon request, we will try to provide an estimate of coverage for you. However, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid and you are responsible for your balance regardless of your insurance coverage.

Insurance payments are ordinarily received within 30 days from the time of filing. If your insurance company has not made payment in 60 days, we ask that you contact your insurance company to make sure it has been processed and when to expect payment. If payment is not received, or your claim is denied, you will be responsible for payment in full at that time.

We thank you for allowing us to participate in your health care and welcome any questions you may have regarding your care or our financial requirements.

I have read, understand, and agree to the above terms and conditions. This statement serves as authorization to my insurance company to pay my medical benefits directly to your office. If my account is past due 90 days or more and I have not made arrangements for payment, I will be responsible for all fees incurred for collections and/or attorney fees.

Patient Signature: _____

Date: _____

Signature of Parent/Guardian if Minor: _____

Date: _____