PATIENT REGISTRATION INFORMATION

PATIENT INFORMATION

Last Name:	Address:
First Name:	
SSN:	City/St/Zip:
DOB:	Driver License #:
Marital Status:	Sex: Race:
Home Phone: * P S N	Work Phone: * P S N
Cell Phone: * P S N	Email: * P S N

*P S N – Please indicate your contact preference above: P=Primary S=Secondary N=No, do not contact here.

RESPONSIBLE PARTY INFORMATION

Last Name:	Address:
First Name:	
SSN:	City/St/Zip:
Home Phone: * P S N	Work Phone: * P S N
Cell Phone: * P S N	Email: * P S N

To assist you in providing a preprinted claim form that **you** may submit to your insurance company, please complete the following insurance information – If you have **MEDICARE**, you must complete a private contract with our office before you are seen by the doctor

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Group #:	Group #:
Contract #:	Contract #:
Address:	Address:
City: State: Zip:	City: State: Zip:
Service Code:	Service Code:
Insured Party:	Insured Party:

EMERGENCY CONTACT (Not currently living in your household)

Last Name:	Address:
First Name:	City:
Phone No:	State: Zip:
Alternate Phone No:	Relationship:

PATIENT ACKNOWLEDGEMENTS

By signing below, I acknowledge and understand that all costs associated with receiving services at the Wycoff Wellness Center are the sole financial responsibility of me as the patient. I understand that payments for services are due in full at the time of service. I understand that Wycoff Wellness Center has opted out of Medicare and I can not submit a claim to Medicare. I understand that Wycoff Wellness Center, will provide me with the necessary information for submission to my insurance company, but will not assume any responsibility in assuring my reimbursement.	By signing below, I acknowledge that I have been offered and have received the Wycoff Wellness Center Notice of Privacy Practices. In compliance with HIPAA practices, I authorize Wycoff Wellness Center to leave messages at/with (circle all that apply): Home Work Email Do Not Leave Messages Household Members Answering Machine/Voice Mail
Signature:	Signature:
Date:	Date:

Witness:	Witness: