PLEASE COMPLETE ALL INFORMATION

PATIENT'S
NAME _____ ***DOB***_____***AGE***_____
LAST FIRST M.I.

ADDRESS_____ _____ _____ _____
STREET CITY STATE ZIP

HOME
PHONE(_____)_____
WORK
PHONE (_____)_____

CELL
PHONE (_____)_____
EMAIL_____

SOCIAL SECURITY NUMBER_____

PARENT, IF PATIENT IS A MINOR,
OR RESPONSIBLE PARTY NAME_____

PHONE_____

ADDRESS_____ _____ _____ _____
STREET CITY STATE ZIP

*

OCCUPATION_____

EMPLOYER_____

ADDRESS_____ _____ _____ _____
STREET CITY STATE ZIP

*

SPOUSE EMPLOYER_____

ADDRESS_____ _____ _____ _____
STREET CITY STATE ZIP

REFERRED BY_____

REASON FOR OFFICE VISIT_____

RELEASE AND ASSIGNMENT: I authorize and request my insurance company to pay directly to the doctor the amount due me in the pending claim for medical or surgical services. A photographic copy of this shall be valid as the original. I understand that I am financially responsible for all charges not paid by the insurance company. If my account is not paid within 90 days, I shall be liable for an additional amount equal to 1.5% of the remaining principal balance. I agree that in the event my account is turned over to a collection agency, I will pay a collection fee equal to 35% of the amount due. I hereby authorize Dr. James W. Wade to release any information including diagnosis and records of any treatment or examination tendered to me during the period of such medical care to any person, company or firm necessary to process my claim. I hereby authorize Dr. James W. Wade to release any medical information for peer review.

NAME _____ ***DATE*** _____