Kimberly M. Wise, M.D.

PLEASE PRINT **Today's Date: _____**

Patient Information

Name: _____ Social Security No _____
Last First MI

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age_____ Sex: F M Marital Status: S M W D

Home Phone _____ Work Phone _____ Cell Phone _____

Employer: _____ Previous occupation if retired: _____

Is it ok to leave a message at your **Home:** Yes No **Work:** Yes No

Spouse's Name _____ Employer _____ Work Phone _____
(or Parent if Minor)

Insurance Information

Primary Insurance Name: _____ Card Copied: YES NO

Policy Holder's Name _____ DOB _____ Social Security No _____

Relationship to Patient_____ Policy Holder's Employer _____

Secondary Insurance Name: _____ Card Copied: YES NO

Policy Holder's Name _____ DOB _____ Social Security No _____

Relationship to Patient_____ Policy Holder's Employer _____

Emergency Contacts *(Other Than Spouse)*

Name _____ Relationship _____

Phone No. _____ Alternate No. _____

Referring Doctor/Primary Care Doctor _____

Responsible Party Statement and Payment of Benefits

I understand that I am financially responsible for all charges that are not directly paid by my insurance company. If the doctor is a participating provider on my insurance I understand that I am responsible for any co-pay, coinsurance or deductible not paid by my plan. I authorize the release of information/records to my insurance company as necessary to process my insurance claim. I authorize my insurance company to pay benefits directly to **Kimberly M. Wise, M.D.**

Signed: _____ Date: _____