THOMAS J. WEIGEL, M.D SC
Thomas J Weigel, M.D.
Guy Randolph, M.D.
Justin N. Uhl M.D.

PATIENT ____ BIRTHDATE_________
(Last name) (First name)

HOME ADDRESS: __________________________ CITY_____________ ST____ZIP _____

HOME PHONE: (_____) ________________________ SS# __________________________________

CELL PHONE (_____)____________________ email _______________________________

RESPONSIBLE PARTY (INSURED)

NAME_________________________________ BIRTHDATE _______ SS#_________________

Relationship to patient: _______________ ADDRESS: ____________________________
Phone: ________________________ CITY__________ _________ ST__ZIP______

EMPLOYER: __________________________________ OCCUPATION ________________

ADDRESS:_______________________________ CITY______________ ST ____ ZIP

WORK PHONE (__) __________________________ EX_____

OTHER RELATIVE (mother or father)
NAME: __________________________ Birthdate: ______________SS#________________
Relationship to patient: _______________ ADDRESS________________________________
Phone: _________________________ CITY __ST ZIP
EMPLOYER: _________________________________OCCUPATION ____________________

ADDRESS: _______________ CITY___________ST ZIP____________

Emergency contact: (not living with patient)
NAME: ________________________________ Relationship to patient ________________

PHONE: (___) ________________________

INSURANCE INFORMATION:

INS CO NAME: _________________________________
POLICY HOLDER'S NAME _____________ ___________
ID# ____
GROUP# ____________________________

REFERRING PHYSICIAN
Name: _____________________________
Address; __________________________
City__________________ST___Zip_____
Phone: ____________________________

HMO REFFERAL ARE YOUR RESPONSIBILITY
MAKE SURE YOU HAVE IT FOR THE APPT.

I authorize the practice to release any Information including, but not limited to, the diagnosis and records of all examinations and treatments during the period of such care to insurers and other healthcare practitioners.

I authorize and request my insurance company to pay directly to the practice all benefits otherwise payable to me for each visit.

I understand that my Insurance company may pay less that the total bill for services. I agree to be responsible for all co•pay amounts, deductible amounts and additional balances not covered by my insurer(s)

Signature, ___________________________________ DATE: ____________________________