Patient Information

Patient's Last Name: ____________________ First Name: ____________________ MI: __________

Street Address: ____________________ Apt # : __________ City: ____________________

State: ______________ Zip: __________

Home Phone# (   ) ____________________ Work# (   ) ____________________ ext: __________

Cell: (   ) ________________ Social Security # _____/ _____/ _______ Date of Birth: ____/____/______

Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Separated ☐ Divorced

Emergency Contact: ____________________ Relationship: ______________ Phone# (   ) ______________

Employer Information

Name of Employer: ____________________ Address: ____________________

City: ________________ State: __________ Zip: __________ Telephone# (   ) ________________

May we contact you at work? ☐ Yes ☐ No Occupation: ____________________

Primary Insurance (copy of card will be attached)

Primary Insurance Name: ____________________ Telephone: (   ) ____________________

Address: ____________________ City ________________ State _______ Zip ______________

Policy # ________________ Group# __________ Copay $ ________ Effective Date: ____/ _____/ _____

Name of Insured: ____________________ Relationship to Patient: ☐Self ☐Spouse ☐ Child ☐ Other__________

Insured Date of Birth: _____/ _____/ _______ Insured SS# ________ - ________ - __________

Secondary Insurance

Secondary Insurance Name: ____________________ Telephone: (   ) ____________________

Address: ____________________ City ________________ State _______ Zip ______________

Policy # ________________ Group# __________ Copay $ ________ Effective Date: ____/ _____/ _____

Name of Insured: ____________________ Relationship to Patient: ☐Self ☐Spouse ☐ Child ☐ Other__________

Insured Date of Birth: _____/ _____/ _______ Insured SS# ________ - ________ - __________

1. I authorize the release of any medical information necessary to process my insurance claim(s) to Millennium Practice Management Associates, Inc.
2. I authorize and request payment of medical benefits directly to my Physician(s) at WHCG.
3. I agree that a photocopy of this form may be used in lieu of the original.
4. I agree to pay all charges not covered by my insurance carrier(s). These charges include but are not limited to deductibles, co-payments, co-insurance and non covered services.

X____________________________ Patient/Authorized Signature

______/______/______ Date