Thank you for selecting Robert C Wright, M.D., P.S. To help us meet your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask and we will be happy to help.

PLEASE PRINT WHEN FILLING OUT THIS FORM Today's date___________________________

PATIENT INFORMATION **Date of Birth:** ______/_____/________

Full Legal Name:

(Last) ___________________________ (First) _________________ (MI) ______ Soc. Sec # _______-________-_______

Mailing Address ____ City______________________ Zip ____________

Street Address: (if diff. from mailing address):________________________________e-mail:________________________

Home Phone ( ) _____-__________ Cell Phone ( ) _______-________ Work Phone ( ) _____- ____________

Check Appropriate Option: Minor ☐ Single ☐ Student ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Patient's Employer (required) _______________________________ Address ______________________________________

Spouse ________________________________ Phone ( ) _______-____________

Referring Physician _________________________ Primary Care Physician (Family Doctor) _________________________

Emergency Contact? (Other than you own number) Name ________________________ Phone ( ) _____-___________

Work ( ) _______-__________ Cell ( ) ______-___________

Who may we thank for referring you to our office if not your referring physician? ____________________________________

GUARANTOR – (Financially responsible person for surgeon and facility fees and charges) **Date of Birth** ____/____/______

Full Legal Name: (Last) ____________________ (First) _______________ (MI) ____ Soc. Sec # ______-_________-______

Mailing Address (if different from patient) _____________________________ City____________________ Zip ___________

Street Address: (if different from mailing Address) ____

Home Phone ( ) _____-___________ Cell Phone ( ) _______-__________ Work Phone ( ) _____- __________

Employer (required) _______________________________Union/Local# _______________ Phone ( ) ______- _______

PRIMARY INSURANCE:

Full Name of Subscriber _____________________________________ Relationship to Patient _________________________

Date of birth ____/____/____ Soc. Sec # ______-_________-_______ Length of Employment ______________________

Subscriber's Address (required) ____________________________ City ________________________ Zip ______________

Employer (required) _______________________________ Union/Local# _________________ Phone ( ) ______- ______

Insurance Company _____________________________ Subscriber ID# ______________ Group ID# _________________

Amount of your deductible? $_________ Amount of your co-pay? $_________ Do we have a current referral on file? _______

(2nd Insurance - Medicare – Industrial Accident – Private Pay: See Reverse Side)

FINANCIAL AUTHORIZATION

- I authorize my insurance benefits be paid directly to my physician.
- I attest that all the information given is true.
- I have read and understand the financial policy or it has been explained to me to my satisfaction.

____ _________________

Signature Date

CONTINUE TO MIDDLE OF BACK PAGE IF NO OTHER INSURANCE

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made on my behalf to Robert C. Wright, M.D., F.A.C.S. and/or Meridian Surgical Center for any services furnished to me by this physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient (or Patient Representative) ______________ Date ______________

Medicare Number ______________

SECONDARY INSURANCE (Please Print)

Full Name of Insured ______________ Relationship to Patient ______________

Date of Birth ____/____/____ Soc. Sec # ______-_________-_____ Length of Employment ______________

Employer (required) ______________ Union/Local# ______________ Phone ( ) _____- _______

Insurance Company ______________ Subscriber ID# ______________ Group ID# ______________

Insurance Company Address ______________ City ______________ Zip ______________

LABOR AND INDUSTRY CLAIMS (State and Private through Employer)

Company Administering Plan ______________ Phone ( ) _______- _______

Claim #: ______________ Date of Injury ______/______/________

Claim Manager's Name ______________ Phone ( ) ______- ________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Federal law requires that the notice of Privacy Practices, which is our explanation of how we use and disclose your health information, be made available to all patients. This law also requires that each individual acknowledge that you have been advised of the policy.

You have the right to review our notice, and if you have any questions, to ask for an explanation of any part of the notice, or any other aspects of our use and disclosure of your health information. The terms of our notice may change as the law and our practices change. If we change our notice, we will have revised copies available to you when you visit us and also send you a revised copy upon your request.

We appreciate you signing below, acknowledging that you have received, or have been offered and refused, a copy of our notice.

Patient or Patient Representative's Signature ______________ Date ______________

May our staff contact you or leave a message at these telephones? Home/cell? Yes ☐ No ☐ Work? Yes ☐ No ☐

With whom may we discuss your medical condition or leave messages with in the event we are unable to reach you or you are medically not able to understand?

____

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Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. Ask questions at any time. The staff members are happy to help you.

BACK