

# WELCOME



Date: \_\_\_\_\_

1. **Patient Name:** \_\_\_\_\_ (wishes to be called \_\_\_\_\_)

Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SS#: \_\_\_\_\_ Home Phone#: ( ) \_\_\_\_\_ Cell Phone#: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ Are Calls Allowed? \_\_\_\_\_

Where do you prefer calls?  Home  Cell  Work

When is the best time to reach you? \_\_\_\_\_ Days \_\_\_\_\_

Male  Female  Minor (under 18)  Single  Married  Divorced  Widowed  Separated  Partner

Primary Doctor:  Dr. Michelle Davis  Dr. Cindy Opolka  Dr. Pamela Zelasko

How did you hear about us? \_\_\_\_\_

2. **Person and Address where bills should be sent. If same as above, check here:**  Same as above

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone#: ( ) \_\_\_\_\_ Cell Phone#: ( ) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security#: \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ Are Calls Allowed? \_\_\_\_\_

### 3. Insurance Information

#### Primary Insurance

Policy Holder \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Co \_\_\_\_\_

Contract # \_\_\_\_\_

Group # \_\_\_\_\_

#### Secondary Insurance (if any)

Policy Holder \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Co \_\_\_\_\_

Contract # \_\_\_\_\_

Group # \_\_\_\_\_

### 4. Emergency Contact Information

In the event of an emergency, who should we contact?

Name: \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

#### Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatments or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize West Michigan Family Medicine physicians to treat my child or me.

X \_\_\_\_\_ (Signature of Patient or Parent if minor)

Office use only: 2009 \_\_\_\_\_ 2010 \_\_\_\_\_ 2011 \_\_\_\_\_ 2012 \_\_\_\_\_