Fox Valley Wellness Center | 180 Knights Way Fond du Lac, WI 54935 | PH: 877-676-LIFE (5433) or 920-922-LIFE (5433)

PATIENT REGISTRATION 01/01/2016

PATIENT

Patient Name : ____ DOB___/___/_____

Address: ____ Phone#______________________

City/State/Zip: ______________________________ County________________ Cell #_________________

Marital Status: S / M / D Sex: Male / Female Maiden Name:_____________________

Social Security #_________________________ Email Address: ______________________________

Responsible Party for Medical Expenses

__Parent ___Self ___Spouse *(if self go to insurance section)* Phone_________________________________

Parent or Spouse's Name______________________________ DOB___/___/____ SS#________________________

Address____ Employer_____________________________________

Medical Insurance Company

Primary Insurance: __________________________________Group#_________________ ID#____________________

Date of Birth of Insured: __ /__ /___

Subscriber Name:___________________________________ Covers: __Self __Family Effective Date:__/__/___

Secondary Insurance:_______________________________ Group# _________________ ID# _________________

Subscriber Name:__________________________________ Covers : __Self __Family Effective Date:__/__/___

Date of Birth of Insured: __ /__ /___

Emergency Contact

Name:____ Relationship: _____________________________

Street:____ Phone: _________________________________

City/State/Zip:____

Authorization for Release of Information

Authorization is hereby granted to release to the above named Insurance Company. Such information may be necessary for the completion of my clinic claims. I understand I am financially responsible for charges not covered by insurance and assign any insurance benefits to above said clinic.

Signature____ Date:_____________________

Who do we thank for referring you to us today? ____

MT/TB