TOTAL WELLNESS FAMILY MEDICINE

PATIENT INFORMATION

Patient Name: Last______________________ First______________________ Mid Initial___________

Address:____ Home Phone:_______________________

City:____________________ State:________________ Zip:________________ Cell Phone: ______________

Date of Birth:_______________ Social Security#:_____________________ Other Phone: _________________

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's Employer:____ Occupation:_____________________

Employer Address:____ Wk. Phone:______________________

City:____ State:________________ Zip:____________________

Worked-related Injury: ☐ Yes ☐ No Automobile Accident: ☐ Yes ☐ No Date of Injury/Accident:___________

Emergency Contact:______________________ Relationship______________ Telephone:____________________

Advanced Directive: Yes No Copy on File: Yes No Retired ☐ Yes ☐ No

Referred by:____

Email address for appointment referrals:____

IF DIFFERENT FROM ABOVE – POLICY HOLDER/INSURED INFORMATION – Primary Insurance

Insured Name:____ Phone:_________________________

Address:____

City:____ State:________________ Zip:____________________

Date of Birth:__________________________________ Social Security#:_________________________________

Employer:____ Wk. Phone:______________________

Employer Address:____

City:____ State:________________ Zip:____________________

Primary Insurance:____ Phone:_________________

Group#:____ Policy#:____

INSURANCE COMPANY INFORMATION – Secondary Insurance

Insured Name:____

Address:_________________________________ **City:**________________ **State:**____________ **Zip:**____________

Date of Birth:___________________ Social Security#:_____________________ Phone #:____________________

Secondary Insurance:____ Phone:_____________

Group#:____ Policy#:____

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance company and I assign benefits to Kimberly A Adams MD PC dba Total Wellness Family Medicine. We will gladly file your insurance claim, however payment for copays and deductibles are required at the time services are rendered. We cannot guarantee payment to Kimberly A Adams MD PC dba Total Wellness Family Medicine. We have an agreement with you, not your insurance company for payment. In the event your insurance company denies a claim, you will become responsible for all amounts not covered payable to Kimberly A Adams MD PC dba Total Wellness Family Medicine. Parents/Guardians are responsible for services rendered to a minor. If your account is turned over for outside collections, you will be responsible for all costs of the outside collection agency.

I authorize release of all medical records to referring and primary care physicians and the insurance company, as applicable.
I authorize fax transmission of medical records of necessary.

SIGNATURE:____ Date:_____________________________