WISDO FAMILY MEDICINE

James John Wisdo, D.O., P.A.
Christine A Kogoy, PA-C

NEW PATIENT INFORMATION

Current Date: _____

Patient Name: _____ Mr. __ Mrs. __ Miss__ Ms. __

Mailing Address: _____Phone # _____

City: _____ State: _____ Zip Code: _____

*Street Addresses #2: _____

City: _____ State: _____ Zip Code: _____

Marital Status: Single ____ Married _____ Divorced ____ Widowed ____

Date of Birth: _____ Sex: Male ____ Female _____ Social Security # _____

Spouse's Name: _____ Spouse's date of birth: _____

Employer/School: _____ Occupation: _____

City: _____ State: _____ Zip Code: _____

Work phone #_____ Okay to contact you at work: Yes ____ No ____

INSURANCE INFORMATION:

Primary Insurance: _____ Policy # _____ Group # _____

Subscriber's Name: _____ Subscriber's Social Security # _____

Subscriber's Date of Birth: _____ Patient's relation to subscriber _____

IF PATIENT IS A MINOR:
ARE YOU THE LEGAL GAURDIAN? Yes_____ No_____

Name: _____ Social Security # _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: (____) _____ Work # (_____) _____

How did you hear about us? _____
FAMILY, FRIEND, DOCTOR, PHONE BOOK, NEWSPAPER, ETC

Living Will: Yes _____ N0 _____

*FOR THOSE PATIENTS WHO RESIDE ELSEWHERE PART OF THE YEAR.

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IN CASE OF EMERGENCY:

Name of friend or relative (not living at the same address)_____

Phone # _____ Work # _____ Cell # _____

I hereby give consent for treatment and herby authorize any physicians, hospital, and or medical facility to release any information concerning my medical history and treatment.

I hereby authorize release of medical information including positive exposure to HIV infections, ARC, AIDS, alcohol or drug dependency, mental and nervous disorders to other physicians, hospitals, or medical facilities that may be included in my care.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Wisdo Family Medicine or my insurance company to release any information required to process my claim.

Print Patient Name: _____

Patient Signature: _____ Date: _____