E. Brooks Wilkins Family Medicine, PA
4020 Wake Forest Rd., Ste 201
Raleigh, NC 27609
www.ebwmd.com

Internal Use: **Year 2014**

Chart #

New Patient _____
Established Patient_____

PLEASE PRINT ALL ENTRIES. THANK YOU.

PATIENT INFORMATION					
Last Name:	First Name:		Middle Initial:	Social Security Number:	
Date of Birth: (mm/dd/yy)	Sex: (Circle One) M F		Marital Status: (Circle One) S M D W Sep		
Home Address:	Apt:	City:	State:	Zip Code:	
Home Phone: ( )	Work Phone: ( ) Ext.		Cell Phone: ( )		
Billing Address (if different from Home Address):		E-mail:			
EMERGENCY CONTACT					
Name:	Relationship to Patient:	Home Phone: ( )			
		Cell Phone: ( )			

In order to control the cost of billing, office visit charges incurred **must be paid at the time of service** if insurance coverage is unavailable. **Any and all charges incurred, denied, or non-covered by your insurance carrier must be paid immediately upon denial.** Arrangements for a payment plan should be made prior to your office visit.

Do you have insurance? Yes No

PLEASE FILL IN THE INFORMATION BELOW.

PRIMARY INSURANCE: Subscriber Information		Effective Date:	
Subscriber Name (last, first, middle initial):	Social Security Number:	Date of Birth: (mm/dd/yy)	Sex: M F
Insurance Company Name:	Insurance ID/Subscriber Number:	Group Number:	
Insurance Address:		Relationship to Patient:	
SECONDARY INSURANCE: Subscriber Information		Effective Date:	
Subscriber Name (last, first, middle initial):	Social Security Number:	Date of Birth: (mm/dd/yy)	Sex: M F
Insurance Company Name:	Insurance ID/Subscriber Number:	Group Number:	
Insurance Address:		Relationship to Patient:	

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize payment directly to E. Brooks Wilkins Family Medicine, PA for Medical and/or Surgical Benefits for services as described on the encounter form, but not to exceed the reasonable and customary charge for those services.

X_____ Date_____, 2014
Signature

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize E. Brooks Wilkins Family Medicine, PA to release any information acquired in the course of examination or treatment to other medical providers as the physician deems necessary. The practice may release information to specific insurance carriers, third party payers, or others involved in processing and collection of claims.

X_____ Date_____, 2014
Signature