SINGLE MARRIED DIVORCED WIDOWED Today's Date ______________

Check here if new patient:______________ Family Physician ______________

PATIENT INFORMATION

Last Name______________ First______________ Initial______ Maiden ______________

Street Address______________ Home Phone______________

City______________ State__________ Zip__________ Work Phone ______________

Mailing address if different from above ______________

Employer______________ Date of Birth__________ Age______ SS# ______________

Whom may we thank for referring you? ______________

SPOUSE OR PARENT INFORMATION

Last Name______________ First______________ Initial______ SS#______________

Address______________ City______________ State__________ Zip ______________

Home Phone______________ Work Phone______________ Employer ______________

Name / Phone # person to contact in case of Emergency:______________

Relationshp to Patient______________

INSURANCE INFORMATION

Do you have Medicaid assistance?______________

Do you have Medicare assistance?______________

Authorization for Release of Information and Assignment of Benefits

I authorize Dr. Nowak and/or Terri Glenn, FNP, (providers), to release all medical information (including but not limited to, information on psychiatric conditions, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare or any other third-party payers. I authorize providers to release all medical information to my referring physician and my primary (family) physician. I authorize providers to release all medical information to any hospital, which I may enter under the direction of providers. I authorize providers to release all medical information to any laboratory, which may process my laboratory specimens. I authorize providers to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to providers. I hereby authorize my insurance benefits to be paid directly to providers, realizing that I am responsible to pay non-covered services.

I agree that these provisions will remain in effect until I provide written revocation to providers.

Signature of Patient/Legal Guardian:______________ Date ______________