

DATE: _____

Wilson Medical
307-733-2855

Michael J Menolascino, MD
Sally H. Luke, C-FNP
Rafael Williams, MD

NAME (Last, First, Middle)		SSN:	Date of Birth	Sex:
MAILING ADDRESS:		CITY, STATE, ZIP		
PHYSICAL ADDRESS		CITY, STATE, ZIP		
HOME PHONE	CELL PHONE	WORK PHONE	EMAIL ADDRESS:	
EMPLOYER:	OCCUPATION:	SPOUSE/PARTNER:		TELEPHONE #:

DATE OF INJURY OR ONSET:

INSURANCE CARRIER (PRIMARY)	NAME OF INSURED	POLICY #:	GROUP #:
ADDRESS OF INSURANCE COMPANY:	INSUREDS DATE OF BIRTH:	RELATIONSHIP TO INSURED:	
CITY, STATE, ZIP:	IF BCBS, CO-PAY AMOUNT:	INS COMPANY PHONE NUMBER:	EFFECTIVE DATE:
SECONDARY INSURANCE (If Medicare)	NAME OF INSURED	POLICY #:	GROUP #:
ADDRESS OF INSURANCE COMPANY:	CITY, STATE, ZIP:	TELEPHONE #:	

IF MINOR, RESPONSIBLE PARTY:

IF MINOR, RESPONSIBLE PARTY:	SS#:	DATE OF BIRTH:	TELEPHONE #:
MAILING ADDRESS:	CITY, STATE, ZIP:	RELATIONSHIP:	

IS THIS A WORK RELATED INJURY?

IS THIS A WORK RELATED INJURY?	DATE OF INJURY:	STATE WHERE INJURED:	CASE NUMBER:
WORKER'S COMPENSATION CARRIER:	CITY, STATE, ZIP:	TELEPHONE #:	

NATURE OF INJURY:

IF THIS IS A WORKER'S COMP INJURY, YOU WILL BE BILLED UNTIL YOU SUPPLY US WITH ALL OF THE INFORMATION ABOVE.

YOUR DRUGSTORE NAME:

YOUR DRUGSTORE NAME:	FAMILY PHYSICIAN:
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IN THE EVENT OF AN EMERGENCY, WHO SHOULD BE NOTIFIED?

IN THE EVENT OF AN EMERGENCY, WHO SHOULD BE NOTIFIED?	TELEPHONE #:
WHO ARE YOU SCHEDULED TO SEE TODAY?	MAY WE LEAVE A GENERAL MESSAGE ON YOUR VOICEMAIL IF NECESSARY? YES _____ NO _____

PLEASE BE PREPARED TO PAY AT TIME OF SERVICE. WE ACCEPT VISA, MC, & DISCOVER. WE WILL SUPPLY YOU WITH THE INSURANCE FORM TO SUBMIT TO YOUR INSURANCE COMPANY FOR REIMBURSEMENT.

SIGNATURE: _____ **NAME:** _____

(Patient, Parent or Legal Guardian's Name)

By signing above as the Patient, Parent or Legal Guardian, I authorize medical treatment, understand the financial policies of this office, and have been offered and read Wilson Medical's Notice of Privacy Practices (HIPPA).

HOW DID YOU HEAR ABOUT US? _____