BRIAN S. TAYLOR, MD & JOYCE E. WECKL, PMHNP

PATIENT INFORMATION

Please complete all fields and provide us with a copy of your photo identification & insurance card(s) as applicable.

LAST NAME: _____ FIRST: _____ MI: _____

HOME ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ SEX/IDENTIFIED AS: M F Other: _____

DOB: _____ RACE/ETHNICITY_____ EMPLOYER: _____

HOME PHONE: _____ WORK PHONE: _____ EXT. _____

CELL PHONE: _____ OKAY TO LEAVE A MESSAGE? YES NO

SS # _____ NAME YOU WOULD LIKE US TO CALL YOU:_____

EMAIL: _____ MARITAL STATUS: S M D W Other: _____

FAMILY PHYSICIAN: _____HOW DID YOU HEAR ABOUT US: _____

FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN PATIENT): _____

PHARMACY NAME:_____ PHARMACY LOCATION:_____

INSURANCE INFORMATION

INSURANCE: _____ _____ IS THIS YOUR PRIMARY INSURANCE? YES NO

INSURANCE ID # _____ GROUP OR PLAN # _____

POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICY HOLDERS SS # _____ DOB: _____

IS INSURANCE THROUGH EMPLOYER? YES NO INSURED'S EMPLOYER: _____

DO YOU HAVE A SECONDARY POLICY? YES NO NAME OF PLAN: _____

INSURANCE ID # _____ GROUP OR PLAN # _____

INSURED'S NAME: _____ INSURED'S DOB: _____

IN CASE OF EMERGENCY NOTIFY_____ **PHONE #** _____

RELATIONSHIP TO PATIENT: _____

I CERTIFY THAT ALL INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. UPON A CHANGE IN MY INFORMATION, I WILL IMMEDIATELY PROVIDE UPDATES TO THIS OFFICE. I UNDERSTAND THAT ALTHOUGH I MY HAVE INSURANCE, I AM ULTIMATELY RESPONSIBLE FOR PAYMENT. I AUTHORIZE MY INSURANCE COMPANY TO SEND PAYMENT FOR SERVICES DIRECTLY TO THIS OFFICE AND AGREE TO PAY THE DIFFERENCE. I AUTHORIZE DR. TAYLOR AND/OR JOYCE WECKL TO RELEASE ALL INFORMATION NECESSARY FOR MY INSURANCE TO PAY OR CONSIDER MY CLAIMS.

PATIENT SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____
(IF PATIENT IS A MINOR)