



PLEASE ANSWER ALL QUESTIONS

PATIENT INFORMATION

NAME: LAST _____ FIRST _____ MIDDLE _____
BIRTHDATE _____ SS# _____ SEX _____ RACE _____ ETHNIC ORIGIN _____
HOME PHONE _____ CELL PHONE _____
ADDRESS _____ ADDRESS 2 _____
CITY _____ STATE _____
ZIP CODE _____ 4 DIGIT _____ COUNTY _____
COUNTRY _____ MARITAL STATUS _____
EMPLOYER _____ ADDRESS _____
WORK PHONE _____ EXT _____ PRIMARY CARE DOCTOR _____

INSURANCE INFORMATION

1) INSURANCE CO _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____
2) INSURANCE CO _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____
MEDICARE/ID# _____ MEDICARE/ID# _____
GROUP # _____ GROUP # _____

POLICY HOLDER INFO

NAME _____
RELATIONSHIP TO PATIENT _____
SS# _____
DATE OF BIRTH _____
EMPLOYER _____
ADDRESS _____
CITY _____ ST _____ ZIP _____

POLICY HOLDER INFO

NAME _____
RELATIONSHIP TO PATIENT _____
SS# _____
DATE OF BIRTH _____
EMPLOYER _____
ADDRESS _____
CITY _____ ST _____ ZIP _____

(1) I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the cost of the interest, collection and legal action (if required). (2) I authorize my insurance carrier to release information regarding my coverage to Wilmington Health Associates. I also authorize agents of any hospital, treatment center or previous physicians to furnish copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within Wilmington Health Associates. (3) My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Wilmington Health Associates. This assignment covers any and all benefits under medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will insure such payment to Wilmington Health Associates.

Patient Signature _____

Date/Time _____

Responsible Party Signature _____

Date/Time _____

A copy of this authorization and assignment shall be considered as valid as the original.