WILLIAM E. WOODS, M.D., S.C.
PATIENT INFORMATION SHEET

Name _____
Last **First** **MI**

Address _____ **Apt.**_____
Street **City** **State** **Zip code**

Email address: _____

Best Contact # ( ) _____ **Alternate # ( )** _____
(Home/Cell/Work - please circle one) **(Home/Cell/Work - please circle one)**

Date of Birth _____ **Soc. Sec #** _____

Please complete the following:

RACE: _____ **ETHNICITY:** _____ **LANGUAGE:** _____

Marital Status: Single Married Widowed Divorced Separated Other _____ **(Please circle one)**

REFERRED BY? _____ ******* Primary Care Physician name** _____

Patient Employer _____ **How Long?** _____

Address _____

Patient Occupation _____

Insurance Policyholder's Name _____
(If patient, skip to Medical Waiver)

Policyholder Employer _____ **How Long?**_____

Address _____
Street **City** **State** **Zip code**
Phone ( ) _____ **Occupation** _____

Policyholder Soc. Sec # _____ **Policyholder's DOB** _____

MEDICAL WAIVER:

Please provide us with phone numbers where you would like us to contact you with test results and medical information.

_____ _____ _____

If you are not available at the time we try to call you, may we leave medical information on your answering machine or voicemail? _____ **Yes** _____ **No**

If you are unavailable when we call you, please list the name and telephone number of any other person (s), i.e. husband/partner, child, parent, authorized to receive and discuss your personal medical information.

_____ _____ _____

EMERGENCY CONTACT:

Name _____ **Relationship** _____ **Phone** _____

PRIMARY INS. COMP. _____ **SECONDARY INS. COMP.** _____

Policyholder Name _____ **Policyholder name** _____

Things to bring to your appointment: Photo ID, Insurance card and Insurance Prescription card and/or Prescription Mail order form.

Updated by: _____
Signature **Date**