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 _____**Telephone# ( )**_____

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:

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

Please record below the name and telephone number of any person you authorize to speak with us on your behalf. We will not be able to speak with anyone on your behalf if their name is not listed below.

Name _____ **Phone #** _____ **/// Name** _____ **Phone #** _____

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: _____

Patient Signature **Date**