# SAMUEL R. WILLIAMS, M.D., P.A.

## ADULT PATIENT INFORMATION

Last Name _____ First Name _____

Sex ☐ M ☐ F Birthdate _____ SS # _____

Home Address _____
Street

City _____ State _____ Zip _____ Telephone _____

Telephone _____ Cell Phone _____

Whom may we thank for referring you? _____

Children's Names Birthdate

_____

_____

_____

_____

_____

Patient is: (circle) Single Married Separated Divorced Widowed

## EMPLOYMENT INFORMATION

Employer _____

Address _____

_____

Work Phone _____

Occupation _____

## SPOUSE'S INFORMATION

Spouse's Name _____

Address (if different from patient's) _____

_____

Home Phone _____ Work Phone _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Occupation _____

## EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

## INSURANCE INFORMATION

Primary Insurance: _____

Complete Mailing Address: _____

_____ Phone # _____

Policy Holder's Name: _____ Relationship _____

Policy # _____ Group # _____

Secondary Insurance: _____

Complete Mailing Address: _____

_____ Phone # _____

Policy Holder's Name: _____ Relationship _____

Policy # _____ Group # _____

## RELEASE AND ASSIGNMENT

**Person(s) financially responsible** _____

AUTHORIZATION TO Samuel R. Williams, M.D./PA

I hereby authorize payment of any medical insurance benefits for which I am entitled to be made directly to the above provider. I agree to pay the balance of any charges not paid or covered under my insurance plan. I also authorize release of medical information necessary to process any and all claims to Samuel R. Williams, M.D./PA and their billing agent.

_____ _____

Signature of Parent/Guardian Date