



403 N. Grand Ave Waukesha, WI 53186  
262-547-3055

19035 W. Capitol Drive Ste 102 Brookfield, WI 53045  
262-781-0420

### PATIENT INFORMATION SHEET

PATIENT NAME \_\_\_\_\_ SSN# \_\_\_\_\_

ADDRESS \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_ HOME PHONE# \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ [ ] MALE [ ] FEMALE CELL PHONE# \_\_\_\_\_

MARITAL STATUS: [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] WIDOWED [ ] SEPARATED

PATIENT'S EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_ WORK PHONE# \_\_\_\_\_

**RESPONSIBLE PARTY** \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ SSN# \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

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**CASH PAYING** \_\_\_\_\_

**PRIMARY INSURANCE** \_\_\_\_\_ INS PHONE # \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

SUBSCRIBER SSN# \_\_\_\_\_ ID/GROUP# \_\_\_\_\_

EMPLOYER NAME/ADDRESS \_\_\_\_\_

**SECONDARY INSURANCE** \_\_\_\_\_ INS PHONE # \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

SUBSCRIBER SSN# \_\_\_\_\_ ID/GROUP# \_\_\_\_\_

EMPLOYER NAME/ADDRESS \_\_\_\_\_

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**EMERGENCY CONTACT** \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE# \_\_\_\_\_ ADDRESS \_\_\_\_\_

\_\_\_\_\_ AUTHORIZE MESSAGE ON ANSWERING MACHINE

\_\_\_\_\_ AUTHORIZE MEDICAL INFORMATION TO BE LEFT WITH \_\_\_\_\_.

**GENERAL CONSENT**

I HEREBY AUTHORIZE DIRECT PAYMENT TO PHYSICIAN FOR SERVICES PROVIDED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY **DEDUCTIBLE, COPAYMENTS, AND NON-COVERED SERVICES AT THE TIME OF SERVICE**. IN ADDITION, I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED TO PROCESS CLAIMS TO MY INSURANCE CARRIERS LISTED ABOVE.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_