Kenneth W. Wright, MD Luke W. Deitz, MD

PATIENT INFORMATION

Date _____ Pt: M F

Patient _____
Last First MI

Mother _____

Father _____

Address _____

City _____ ST ____ Zip _____

Phone _____ Cell _____

Patient: Age _____ Birthdate _____

Pt. SS# _____ Pt. DL# _____

REFERRAL INFORMATION

Patient Referred By:

Name _____

Address: _____

City: _____ ST _____ Zip _____

Phone: _____ Fax: _____

Pediatrician/Primary Care Physician Name:

Name _____

Address: _____

City: _____ ST _____ Zip _____

Phone: _____ Fax: _____

Contact Person: _____

CONTACT INFORMATION

If Patient is a minor, custody is with ☐ mother ☐ father ☐ joint ☐ other _____

Information for: (please circle one) mother / father / other Name _____

Address _____ City _____ ST ____ Zip _____ H Phone _____

Cell _____ Fax _____ email address _____

When and where are the best times to reach you? _____

NAMES OF (2) PEOPLE TO NOTIFY IN CASE OF EMERGENCY (Different address & phone # than above)

1) Name _____ Home Phone _____ Work _____
Address _____ City _____ ST ____ Relationship _____

2) Name _____ Home Phone _____ Work _____
Address _____ City _____ ST ____ Relationship _____

EMPLOYER INFORMATION (if a minor, please complete for parent / guardian)

Employer 1: mom / dad / patient _____

Employer's address _____ City _____ ST _____ Zip _____

Phone _____ Fax _____ Profession _____

INSURANCE INFORMATION

☐ **PPO** ☐ **HMO (HMO Auth#** _____**)** ☐ **Medicare** ☐ **Medi-Cal** ☐ **Other:** _____

Primary Insurance _____ **Name on Card** _____

Subscriber's Date of Birth _____ **Subscriber's ID#** _____

Secondary Insurance _____ **Name on Card** _____

Subscriber's Date of Birth _____ **Subscriber's ID#** _____

Insured's Name _____ **Relationship to Patient** _____