

**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_  
Last First Middle Init.

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

SOCIAL SECURITY NO: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_

SEX: M / F MARITAL STATUS: S / M / D / W / SEP

EMPLOYMENT STATUS: \_\_\_ FULL TIME \_\_\_ PART TIME \_\_\_ ACTIVE DUTY \_\_\_ RETIRED

\_\_\_ SELF EMPLOYED \_\_\_ NOT EMPLOYED

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

RESPONSIBLE PARTY: SPOUSE / SELF / GUARDIAN \_\_\_\_\_  
Last First Middle

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

IS THIS A WORK-RELATED INJURY? YES / NO

IS THIS INJURY RELATED TO A MOTOR VEHICLE ACCIDENT ? YES / NO

IF YES: POLICY HOLDER/WORKERS' COMPENSATION CO: \_\_\_\_\_

INJURY DATE: \_\_\_\_\_ CASE/POLICY NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP \_\_\_\_\_

EMPLOYER AT TIME OF INJURY: \_\_\_\_\_

EMPLOYERS ADDRESS: \_\_\_\_\_

PRIMARY MEDICAL INSURANCE:

COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

INSURED'S NAME: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

SOCIAL SECURITY NO: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SEX: M / F

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

SECONDARY MEDICAL INSURANCE:

COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

INSURED'S NAME: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

SOCIAL SECURITY NO: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SEX: M / F

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

We will file your claim for you. We require that any co-payments be made at the time services are rendered. If you have met your deductible you will be required to pay 20% of your daily charges at the time of service. If you are not medically insured, we request that all charges be paid after each office visit. If this account is assigned to a collection agency, or an attorney for collection and/or suit, John E. Winter II, M.D., P.C., shall be entitled to reasonable costs of collection and attorney's fees. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to: John E. Winter II, M.D., P.C. This assignment, will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

RESPONSIBLE PARTY'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES:**  
Acknowledgement of Receipt

By signing this , you acknowledge receipt of the Notice of Privacy of John E. Winter II, M.D., P.C. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change, and we have reserved the right to change it. If we change our notice, you may obtain a copy of the revised notice by contacting our office.

I acknowledge receipt of the Notice of Privacy Practices of John E. Winter II, M.D., P.C.

Signature: \_\_\_\_\_ (patient)

OR

I acknowledge receipt of the Notice of Privacy Practices of John E. Winter II, M.D., P.C. on behalf of \_\_\_\_\_.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_