

**WESTERN MEDICINE, INC. FAMILY PHYSICIANS**

\_\_\_ Jacob T. Dean M.D.

\_\_\_ Perry Kuhn, PA-C

\_\_\_ Sarah Rodewald, CNP

\_\_\_ Aaron T. Groth M.D.

\_\_\_ Edward Clack D.O.

\_\_\_ Trent Nourse, PA-C

<b>Patient Information - Please Print</b>			Date
Patient Name	Birth Date	Age	SS#
Street Address	Home Phone #:		
City/State/Zip Code	Sex: Male /Female		Marital Status
Race: <i>(circle one)</i> African American or Black American Indian	Preferred Language :		
Asian Native Hawaiian White	Ethnic Group: Hispanic or Latino / Not Hispanic or Latino		
Employed by:	Work Phone #:	Cell #	
Spouse's Name (if applicable)	E-mail address :		
<b>Guarantor Information (Person responsible for payment)</b>			
Name	Birth Date	Age	SS#
Street Address	Home Phone #:		
City/State/Zip Code	Sex: Male /Female		Marital Status
Employed by:	Work Phone #:		
<b>ALTERNATE CONTACT PERSON:</b> In the event we are unable to contact you at the above address or phone			
Name	Phone #:	Relationship	
<b>Primary Insurance (Policy Holder Information)</b> Please give your card(s) to the receptionist to copy			
Insurance Coverage ___ Yes ___ No	If no insurance, method of payment		
Insurance Company	Group #	Policy #	
Insured Name	Birth Date	SS#	
<b>Secondary Insurance (Policy Holder Information)</b>			
Insurance Company	Group #	Policy #	
Insured Name	Birth Date		
<b>Name of your Pharmacy, Location and phone # (if known)</b>			
<b>PLEASE READ THE FOLLOWING CAREFULLY AND SIGN WHERE INDICATED.</b>			
<p><b>Payment Policy:</b> I understand that if Western Medicine, LLC, is a participating provider with my insurance, and if I'm responsible for any deductible or co-payment, I am required to pay at time of service. If, however, Western Medicine, Inc. is not a participating provider with my insurance, I understand that I am expected to pay my bill IN FULL at the time of service. If I am unable to do so, arrangements must be made in advance and with the provider's approval, a payment plan may be arranged.</p> <p>Out of courtesy, the physician will submit a claim to my insurance company for me. I agree to assign and authorize payment made directly to the physician of all insurance benefits. I understand it is mandatory to notify my health care provider of any other party who may be responsible for paying for my treatment.</p>			
<b>Signature</b>			<b>Date</b>

**REGISTRATION UPDATES**

Date: \_\_\_\_\_ Reviewed \_\_\_ No Changes Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Reviewed \_\_\_ No Changes Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Reviewed \_\_\_ No Changes Signature: \_\_\_\_\_

