

Western Wake Surgical, PC
155 Parkway Office Ct. Suite 101
Cary, N.C 27518
(919)859-4747

Note: For your convenience, this form can be completed on your computer by using Adobe Acrobat® Reader software. Use the [TAB] key to move between fields. Once complete, simply print the form. If you prefer to complete the form by hand, just print a blank copy and complete.

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|--|----------------------------------|----------------------|-------------|------------------------|------------------|
| Patient Last Name | | Patient First Name | | Middle Initial | Male Female |
| Date of Birth | Patient's Social Security Number | | Home Number | Work Number | Cell Number |
| Mailing Address | | | City | State | Zip Code |
| Home Address if different | | | | | |
| Referring Physician | | Address | | Phone | |
| Primary Care Physician (If different) | | Address | | Phone | |
| Patient's Employer | | | | Phone: | |
| Spouse's Name | | | | | |
| Spouse's Employer | | | | Phone: | |
| Emergency Contact | | Relationship | | Phone | |
| Guarantor (Person Responsible for Bill): | | Telephone | | Social Security Number | |
| Address | | City | | State | Zip Code |
| Primary Insurance | | Name of Policyholder | | DOB of Policyholder | Policyholder SSN |
| Secondary Insurance | | Name of Policyholder | | DOB of Policyholder | Policyholder SSN |
| If Medicare is Secondary please indicate one below: | | | | | |
| Disabled Veteran Group Health Employed Spouse End State Renal Disease | | | | | |
| Workman's Compensation? If yes, please see receptionist for additional forms. (Select One) Yes No | | | | | |

I agree to be responsible for my expenses. I authorize my insurance company, attorney, or any other parties to pay Western Wake Surgical, P.C. directly and provide any information regarding payment of my medical charges. I accept responsibility for any balance due and any items not covered by my insurance company. I authorize the physician to administer medical care as is necessary.

Signature: _____ Date: _____