JAMES D. WETHE, MD

PATIENT INFORMATION

Name _____ Age _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Home Phone # _____ **Cell Phone #** _____ **Work Phone #** _____ **E-mail Address*** _____

Employer Name and Address _____

Emergency Contact _____ Relationship _____ Phone # _____

Whom may we thank for referring you today? _____

OK to contact? ☐ **Mail** ☐ **Home** ☐ **Cell** ☐ **Work** ☐ **Email***

By providing your email address you are agreeing to opt-in to our periodic email updates and notices from the practice. Your information will not be sold nor distributed to a third party. You may unsubscribe at any time.

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INSURANCE INFORMATION

Although Dr. Wethe accepts most insurance, he is not an in-network preferred provider for most plans. Your insurance company is your best resource for determining out of pocket expenses associated with seeing a non-preferred/out-of-network provider.

Primary Insurance: _____Phone #_____

Address: _____

Policy #_____Group #_____Effective Date_____

Authorization for Release of Information

I hereby authorize James D. Wethe, M.D. to release information requested by my insurance company or Worker's Compensation carrier. I also authorize James D. Wethe, M.D. to release information to any hospital or physician to whom I may be referred by this office.

Signature _____ Date _____

Relationship To Patient _____

Assignment of Benefits

I hereby authorize assignment and payment directly to James D. Wethe, M.D. of major medical benefits due me.

I HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY MY INSURANCE.

Signature _____ Date _____ Relationship _____