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