Patient Information

Full Name _____ Birthdate _____
Street Address

_____

City _____State _____ Zip _____
Mailing Address (if different)_____
Home Phone _____ Cell Phone _____
Email address _____
Check Appropriate Boxes ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Check Appropriate Box ☐ Male ☐ Female

Employer _____Occupation _____Work Phone _____
Spouse's Name _____Employer _____Work Phone _____

Primary Care Physician _____ Phone # _____

Preferred pharmacy _____ Phone # _____

If you are new patient, how did you find Dr. Whipple? _____

INSURANCE INFORMATION

Primary Insurance _____ Contract # _____
Subscriber's Name _____ Subscriber's Birthdate _____
Secondary Insurance _____ Contract # _____

For Patients under 19, or if you are cover under parents insurance:
Father's Name _____ Home Phone _____
Employer _____ Work Phone _____
Mother's Name _____ Home Phone _____
Employer _____ Work Phone _____

Please note: *All fees and copayments are due at the time of your visit and can be paid by cash, check or credit card. Returned checks are subject to a $45.00 service charge.
** As a courtesy, we are happy to check your insurance for copay/deductible information. This does not guarantee payment from your insurance company. Please sign, acknowledging responsibility for payment in the event of denial from your insurance company.

Date:_____Signature:_____