

Wright Health & Wellness Center

5050 East Kenosha Street
Broken Arrow, OK 74014

Phone (918) 355-9492
Fax (918) 355-9250

Patient Information

Name _____ Date _____
Home Address _____ City/State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Pager _____ Marital Status: (please circle) Single – Married – Widowed – Divorced – Separated
Date of Birth _____ SSN#: _____ Age _____ Sex: M F
Referred By: _____ Employer: _____
Employer Address: _____ City/State: _____ Zip: _____
Spouses's Name: _____ DOB: _____ Spouse's Employer: _____

Person Responsible for Bill (If other than above)

Name: _____ SSN#: _____ Relationship: _____
Address (if other than above): _____ Home Phone: _____
Employer: _____ Position: _____
Employer Address: _____ Employer Phone: _____

Insurance, Medicare, Workman's Compensation Information

Medicare Number: _____ Medicaid Number: _____

Name of Policy Holder: _____ Relation to patient: _____

	Company or Program	Group Number	Policy Number
1			
2			
3			

In Case of Emergency

Name: _____ Relationship: _____ Phone: _____

Please note that our office has a no-show/no cancellation charge of \$25.00!!

Authorizations

Benefits to Physician: I hereby authorize payments be made directly to the physician for the services rendered. I also understand that I am responsible for any portion of my bill not covered by my insurance company

Release of Information: I hereby authorize release of information for insurance claim purposes. A copy of the above is as valid as the original.

The information above is correct and accurate. My signature below indicates that I understand and approve the assignment of benefits, releases of information as well as the \$25 00 no-show/no cancellation charge.

Signed: _____ Date: _____