

Willowbend Health & Wellness Associates

Phyllis J. Gee, M.D., P.A. Natalie Settele, P.A.C.

Welcome to our practice!

Please be sure to complete all requested information and present your **insurance card with photo ID** at check-in so that we may do our part to make sure your insurance claims are processed correctly. Thank you for your cooperation! Sincerely, Dr. Gee and Staff

PLEASE PRINT

TODAY'S DATE: _____

Patient Information

Name: (First) _____ (MI) _____ (Last) _____
Date of Birth: _____ Age: _____ Marital Status: S M W D
Social Security # _____ Drivers License # _____ State: _____
Address: _____
City, State, Zip: _____
Home # _____ Cell # _____ Work # _____ Ext: _____
Email Address: _____
Emergency Contact Name: _____ Relationship: _____
Mobile Phone # _____ Home Phone # _____
Whom may we thank for referring you to us? _____

Primary Care Physician Information

Name: _____ Phone # _____

Insurance Information

Insurance Co: _____ Phone # _____
Ins. Address: _____
ID # _____ Group # _____
Insured's Name: _____ Relationship to Patient: _____
Insured's Social Security # _____ DOB _____ Sex: M F

Patient, Spouse or Parent Employment (Insured)

The following is for: _____ the patient _____ the spouse _____ parent/guardian responsible for payment.

Employer Name: _____ Phone: _____
Address: _____
City, State, Zip: _____

Spouse or Parent Information (If Insured)

Name: (First) _____ (MI) _____ (Last) _____
D.O.B. _____ SS# _____ Drivers License # _____ State: _____
Address: _____
City, State, Zip: _____
Home # _____ Cell # _____ Work # _____ Ext _____

I hereby assign, transfer, and set over to Dr. Phyllis Gee all my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine benefits. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient or Guardian Signature: _____ Date: _____